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ABSTRACT

The Subcommittee met to examine recent new standards of the Accreditation Council for Graduate Medical Education (ACGME) that require training programs in obstetrics and gynecology to perform and teach abortion techniques, as well as the impact of these standards on program accreditation, and the programs' and students' consequent eligibility for federal assistance. A physician representative of the Christian Medical-Dental Society testified against the ACGME standard arguing that physician conscience, individual choice, and medical discernment were ignored. Robert D'Alessandri of ACGME described how the new standard was developed and announced recent modifications that permit programs to omit this training, but prohibit them from impeding students who wish to obtain abortion training at other institutions. Edward M. Hannigan of the University of Texas at Galveston testified that the new standards were enacted to advance a political agenda. A representative of the American College of Obstetricians and Gynecologists argued that training in induced abortion is necessary for physician preparation. Anthony Levatino of the Albany Medical Center argued that the new standards were established in response to a false perception that there is a shortage of doctors trained to do abortions. Paula Smith of the American Association of Pro-Life Obstetricians and Gynecologists testified against the new standard. A discussion that followed covered political influences, medical training, doctor attitudes, and government role. (JB)

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HEARING ON ACCREDITATION OF GRADUATE MEDICAL EDUCATION

ED 388 152

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ECONOMIC AND EDUCATIONAL OPPORTUNITIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, JUNE 14, 1995

Serial No. 104–19

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HEARING ON ACCREDITATION OF GRADUATE MEDICAL EDUCATION

WEDNESDAY, JUNE 14, 1995

HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON ECONOMIC AND EDUCATIONAL OPPORTUNITIES, *Washington, DC.*

The subcommittee met, pursuant to call, at 1 p.m., Room 2261, Rayburn House Office Building, Hon. Peter Hoekstra, Chairman, presiding.

Members present: Representatives Hoekstra, Barrett, Cunningham, McKeon, Castle, Weldon, Sawyer, Reed, Roemer, and Scott.

Also present: Representative Souder.

Staff present: Vic Klatt, Education Coordinator; George Conant, Professional Staff Member; Deanna Waldron, Staff Assistant; Chris Burk, Media Assistant; Gail Weiss, Staff Director; Kevin Bruns, Counsel/Press Secretary; Laura Greer, Executive Assistant; Chris Collins, Staff Assistant; and Broderick Johnson, Chief Counsel.

Chairman HOEKSTRA. Good afternoon. The subcommittee will now come to order.

I would like to welcome the panel here today. I do have an opening statement, and we will also hear from Mr. Sawyer, if you have an opening statement.

Let me just clarify from the outset that I would have preferred not to hold this hearing today. At the Congress, we rely and have decided to rely heavily on the Accreditation Council for Graduate Medical Education, or ACGME, for making sure that doctors educated in the United States are qualified.

Unfortunately, in February of this year the ACGME chose to expand the agenda of medical training accreditation far beyond simply establishing minimum standards for the profession and have launched into the area of taking sides in an extremely divisive moral and social issue.

It seems clear to me that I, as the Chairman of this oversight committee, and the Congress as a whole have no choice but to address this issue. Abortion has been called the third rail of American politics, an issue so hot that no one wants to touch. The issue involves basic American values, personal liberty, and the protection of innocent life which seem to be in direct conflict. The dilemma often seems intractable, and emotions run high on both sides. This is why the word pro-choice is so appealing to many Americans. It suggests that everyone will agree to disagree; that every person is allowed to live in accord with his or her values.

Whatever the validity of this approach where human life may be at stake, some new developments cannot be called pro-choice. They involve forcing medical training program in obstetrics and gynecology to perform and teach abortion techniques against their will. Such developments seem both anti-life and anti-choice.

It is of special concern to this committee that such coercion would be enforced by threatening to withhold accreditation from programs of graduate medical education, and the matter is of such special concern to Congress because such accreditation may determine whether programs and students receive educational loan benefits and other Federal assistance.

This problem arose on February 14 of this year when the ACGME issued new requirements for residency programs in obstetrics and gynecology. All OB–GYN residency programs will be required to train residents in the various methods of induced abortion.

While individual students with moral or religious objections will be able to opt out, an advocate of the policy has already written that those who object, and this is a quote, "should be required to explain why in a way that satisfies stringent and explicit criteria." This was in the New England Journal of Medicine, Dr. Barbara Gottlieb, entitled "Abortion 1995."

Moreover, no program can completely opt out. Even Catholic programs and others with strong moral objections must set up mechanisms to make sure that training is provided at another location. No conscience protection is provided for faculty members and their staff.

The new requirements scheduled to take effect on January 1 run directly counter to numerous State and Federal enactments on this issue. Federal conscience clauses seek to insure that physicians, students, and residents in medical schools and hospitals will not be discriminated against for refusing to participate in abortion.

In 1988, Congress amended the Education Amendments of 1972 to insure that Federal sex discrimination provisions do not require any educational program or institution to provide abortion benefits to staff and students. The Religious Freedom Restoration Act of 1993 allows any institution to file Federal suit if a law or regulation would require it to act contrary to its religiously based moral code.

The ACGME requirement threatens to place Federal law in conflict with itself. Medicare reimbursements for medical procedures performed by medical residents only if the residency program is accredited by the ACGME. The Health Education Assistance Loan, HEAL, Program allows graduates of medical schools to defer repayment of their student loans during residency, but only if the residence program is accredited by the ACGME.

How can Congress so firmly proclaim protection for students and facilities that refuse participation in abortion and then punish them by denying them the benefits of these Federal programs?

The conflict in State law is no less troubling. At least 41 States have laws protecting the rights of individuals and facilities that refuse to participate in abortion. My own State of Michigan declared that a hospital, clinic, institution, teaching institution, or other health facility may not be required to perform or participate

in abortions, and that such facilities have immunity against any civic or criminal liability or penalty.

Almost every Member of this subcommittee comes from a State with a similar law, and yet many of these same States deny a license to practice medicine to a resident if his or her residency program is not accredited by the ACGME. If that accreditation rests in whole or in part on willingness to provide abortion training, the State has been placed in an untenable position. It seems to be violating its own antidiscrimination law.

Within the medical progression, the new requirement runs counter to current practice and many doctors' convictions. Some witnesses who are present today can speak more credibly than I about the depth of physician's disagreements on this issue. I would only note that the expressed reason for the new ACGME requirement is the widespread unwillingness of OB–GYN programs to make abortion an integral part of their training.

Programs and faculty have been voting with their feet. By one recent study only 12 percent of OB–GYN residency programs make abortion a routine part of their training. Most programs make it available as an optional elective, but then few residents volunteer for the training.

It seems that the new requirement must impose from outside precisely because physicians and residents in the field do not see it as an integral part of responsible medicine.

The broader issue before us is whether accreditation of educational programs is supposed to insure basic competency in a field or to enforce conformity with the ideological view of an organization that has acquired a monopoly on the accreditation process. When that organization enjoys delegated governmental power to determine eligibility for Federal benefits, it would be irresponsible for Congress to ignore such abuse simply to preserve the legal status quo. To preserve everyone's current right to choose whether or not to participate in abortion, new Federal action may be necessary.

In my view, at least, Congress cannot be idle when eligibility for its own programs of Federal assistance is conditioned on involvement in abortion. For this reason I am developing legislation to be introduced in the coming days which will protect institutions and individuals from being discriminated against based on their refusal to perform induced abortions.

But today's hearings do not concern particular legislation. It brings together a representative of the ACGME and several directors and faculty in the OB–GYN programs to deepen our understanding of this problem, what has ACGME done and why, where is this policy leading, and what does it mean for the integrity of standards for the educational accreditation.

I welcome all of the witnesses who have agreed to be with us today, and I invite my colleague Ranking Member, Mr. Sawyer to present his opening statement, and any other Members can present their opening statements for the record.

Mr. Sawyer.

Mr. SAWYER. Thank you, Mr. Chairman. I would like to request that the record remain open for 10 days so that interested individuals and groups may submit written statements for the record.

Chairman HOEKSTRA. Yes.

Mr. SAWYER. I thank you, Mr. Chairman, and wish good afternoon to our panel. I appreciate your discomfort with this hearing on accreditation of postgraduate medical education, I probably for different reasons.

I am concerned that with this hearing the subcommittee once again crosses the jurisdictional boundaries of this committee and stretches the traditional purview of the Federal Government in matters of this kind. The Federal Government has traditionally not involved itself in the accreditation of educational entities, and certainly not to this degree of detail and probably not in matters as volatile as the subject that brings us here today.

By conducting oversight of the standards of medical residency programs, Congress threatens to set a dangerous precedent for increased regulation of the content of educational programs, and for the increased regulation of all kinds of programs. This seems to contradict the position of many Members on your side of the aisle, that being advocacy for a smaller role for the Federal Government.

Several Republican proposals have been introduced which would cut or eliminate the Federal role in education and other domestic areas altogether. Any legislative revision would be an extraordinary and perhaps unprecedented override of the authority of the ACGME on accreditation standards.

The ACGME adopted new standards in February of this year for a number of medical specialties. These requirements were developed by professional medical educators and were developed with great sensitivity for the differing moral and ethical views of the participating institutions and their students and residents. The revised requirements were adopted unanimously by the ACGME and included broad conscience clauses for both individual students and for institutions.

These standards reflect the knowledge of procedures that medical educators and physicians believe are necessary for the health of our Nation.

To close, just let me reiterate my concern about these hearings in particular. I believe we are stepping over our jurisdictional boundaries in conducting oversight hearings on and suggesting legislative changes to accreditation standards made by knowledgeable experts. I am troubled that we may be setting the stage for an even broader intrusion on the accreditation standards of our Nation's institutions of higher education generally.

Mr. Chairman, having said that, I want to thank you for calling this hearing in one sense. The concerns that you have expressed that are shared by some on my side of the aisle and those who believe that these kinds of decisions ought best to be left to those who are most responsible for them, it will provide an opportunity for all of us to get our thoughts on the table.

With that, I yield back to you and we can proceed.

Chairman HOEKSTRA. Great. Thank you.

I cannot help but just say I agree with so much of what you said. Leave it to those best able to make the decisions, which might be individual people who have elected to go into the profession of medicine.

But let me introduce the panel and we will start with the testimony. Our first witness today is Dr. Thomas Elkins, who is from the Department of Obstetrics and Gynecology from Louisiana State University in New Orleans. Welcome.

We have Robert D'Alessandri, the Chairman Designate of the Accreditation Council for Graduate Medical Education. He is joined by John Gienapp, who is the Executive Director of ACGME and has designated Dr. D'Alessandri to deliver the ACGME's statement at this hearing. Welcome to both of you.

Dr. Edward Hannigan, who is Director of the Division of Gynecologic Oncology and Department of Obstetrics and Gynecology, the University of Texas at Galveston. Welcome to you, Dr. Hannigan.

Dr. Frank Ling. Dr. Ling is a Fellow at the American College of Obstetricians and Gynecologists. Welcome.

Dr. Levatino from Renssalaer, New York. Dr. Levatino is an obstetrician, an attorney, and a former abortion practitioner.

And Dr. Pamela Smith, Director of Medical Education, Mt. Sinai Medical Center of Chicago, Illinois.

So welcome to the panel, and we will begin with Dr. Elkins. I would encourage all of you to try to adhere to a five or six minute statement, and that would enable us to get to the questioning and dialogue and interaction a little bit sooner, but we are looking forward to hearing your testimony.

Dr. Elkins.

STATEMENT OF THOMAS ELKINS, M.D., CHAIRMAN, DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, LOUISIANA STATE UNIVERSITY MEDICAL SCHOOL

Dr. ELKINS. Mr. Hoekstra and Members of the committee, I want to thank you for asking me to speak and be a witness in these hearings.

My name is Thomas Edward Elkins. I am a Board certified obstetrician-gynecologist and serve as professor and department chairman of one of our large OB–GYN programs at one of our major universities. I have served previously for five years on the American College of OB–GYN Ethics Committee, and have been very involved for a number of years in programs for under-served women both here and abroad.

I come before you today, however, as an official representative of the Christian Medical-Dental Society. The National CMDS has approximately 10,000 members and has active student chapters in most American medical and dental schools.

In general CMDS has opposed abortion, and I represent one of their more moderate members. In 20 years of medical practice, I have mostly been either in university settings or in Africa and have done over two dozen pregnancy terminations for threat of life to the mother, lethal fetal anomalies, or rape and incest.

I have worn many hats during these years, all of which have influenced my thoughts on abortion. I, like most Americans, understand the futility associated with the abortion issue. I am appalled at the violence and rhetoric of both extremes.

There will be no answers that please all or even a majority on the abortion related issues. It is not a topic I normally discuss in

public. It is with some reluctance, therefore, but a sense of duty, that I speak to you today. It is time to resist some steps that simply continue to go too far.

As Americans and as obstetricians and gynecologists, we have never lost our respect for individual liberties. We protect and defend our patients' rights to confidentiality and pursuit of reasonable health care within a healthy lifestyle.

My own thoughts were very pro-choice 25 years ago, and I openly worked with pro-choice physicians. Dr. Ling and I have worked together for a long time, people I deeply respect. They also readily worked with me.

My thought have been modified the last three and a half years, over the past 20 years of work in the Third World in West Africa. I also worked with the developmental disability population in our own country. It is in critical areas like these that such controversial things as abortion become highlighted and thoughts begin to change.

For well over three and a half years out of the last 20 in Africa, I learned that there are other norms besides autonomy. There is beneficence, justice, pragmatism, and survival that become overwhelming ethical norms in many parts of our world. It was there that I learned that starvation and famine among women lead to infections in utero, that force us to do things like dilatation and evacuation to save women's lives. It is a procedure in which you have to dismember the fetus in utero, take it out and reassemble it on a table to make sure that the procedure has been completed. It does not take too many of these procedures to dampen one's enthusiasm for elective abortion.

Over the past nine years I have been very involved with the formation of residency training in the countries of Ghana and Nigeria. We have developed training programs there that have finally lowered the maternal mortality rates, something that all of the millions of dollars that Americans have spent on family planning and abortion in the Third World have been unable to do.

Yet when we approached the U.S. AID office in Ghana just last year and asked for funding for more doctor training, we were told that it was not family planning or abortion, and we could receive no funds.

I began to understand that in these critical issues there are times that we as Americans express our own values perhaps too harshly and go steps too far.

For nine of the last 15 years, I have served on the Board of Directors for the National Downs Syndrome Congress. I lived through the Baby Doe Era, as many of you did in the 1980s and heard those discussions. In this year we have chosen to take those discussions from the nursery back into the womb by, again, setting a test-up called the triple screen for Downs Syndrome that will be offered to every woman in America in order to identify fetuses with Downs Syndrome in utero in order to give a woman a chance to terminate that pregnancy.

This will cost us over $1 billion in the coming year to terminate part of a population group which has become the most gentle, perhaps the kindest and most progressive group of people in America,

many times our teachers of humility and grace in our society. Again, I think we have gone a step too far.

Now, in 1995, some in the pro-choice community have carried the implementation of their own values and viewpoints into the arena of medical education. In my opinion this is, again, a step too far. Some claim that this will offer answers to what they say is an access problem for people seeking to find abortion in our country.

This is difficult for me to understand when there are no lines outside of abortion clinics in our State, and yet no one over the age of 45 who is a Medicaid or indigent patient in our State even has a public health clinic to find a Pap smear or mammogram.

No lines exist outside abortion clinics in our State, and yet we have waiting lists of over 120 days to get into our Center for Gynecology visit. We do have access problems. I do not see it in abortion.

What about the argument that this will insure adequate expertise for abortions being done if residents learn to do D&Cs by the dozens and even dilatations and evacuations as a result of managing spontaneous pregnancy losses?

Training is more than adequate for the mechanical aspects of abortion. The worry about quality of services seems at best to be contrived and imagined. It does seem very obvious that this is a push to make abortion seem to be just a routine part of OB–GYN care.

An abortion simply is not a routine case for most of us in OB–GYN. It is special because human life is involved, not because the procedure is so special. The fetus is not just another routine piece of tissue that presents itself for excision or removal with all expediency once it is deemed bothersome.

Abortion is truly a life lost, and for most of us life is our most precious possession. To equate it to routine care is to cheapen and demean many of our principles that relate to our respect for life from its inception to the point of death.

What is not protected in the ACGME mandate is for the reasonable program to help reasonable physicians to act autonomously in terms of abortion. Physician conscience, individual choice, and medical discernment are simply ignored by any mandate such as this one by the ACGME.

Unless we hear in just a moment that changes have occurred in the last few days, the ACGME mandate also was in direct violation of existing legislation in many States. To comply with the new requirements would require us to sanction criminal activity in our State unless the changes have been made, which I think we will hear about momentarily.

It is, in my opinion, a time for Americans to regroup and rethink its position on such critical issues as abortion. All extreme opinions become unacceptable in such discussions. Individual freedoms for all involved must be respected, and the politicalization of health care issues must simply be discontinued as much as possible.

When committees introduce political issues, it leads to politicians becoming more involved and not less. The universal language of pain, suffering, and compassionate response is not a vocabulary of political power, and medicine must not be allowed to become a tool to that end.

We once discussed strategies to reduce the number of abortions in our country. Rather than watch both extremes fight one another in all kinds of ways, it is time to retrace our steps and our thoughts.

Thank you.

[The prepared statement of Dr. Elkins follows:]

"Steps That Have Gone Too Far"
A Time for Analysis and Retracing of Thoughts

**Testimony before the United States
House of Representatives Committee
on Economic and Educational Opportunities**

Thomas E. Elkins, M.D.

My name is Thomas Edward Elkins. I am Board Certified in Obstetrics and Gynecology and serve as Professor and Department Chairman of a large OB-GYN program at one of our major universities. I have served previously for five years on the American College of Obstetricians and Gynecologists' Committee on Bioethics, and two years on the National Advisory Board for Ethics in Reproduction. I have become known both here and abroad for the successful development of programs to enhance health care for underserved women. I have worked with others to develop OB-GYN training programs in West Africa that focus on rural problems such as vesicovaginal fistulas resulting from long neglected labor, female circumcision and maternal mortality. In the 1980's, I established model gynecologic clinics and sexuality/socialization counseling programs for women with mental retardation in our country.

I was recruited to my current position, in part, to intervene in the health care problems of one of our nation's largest indigent communities. In less than three years, we have begun a system of inner-city prenatal clinics in housing projects, stationed our faculty in school-based clinics, and assigned faculty to work to improve women's health for all ages throughout the state.

I come before you today, however, as a representative of the Christian Medical Dental Society. The national CMDS has approximately 10,000 members and has active student chapters in most American medical and dental schools. They have taken a very strong official position against abortion for any reason, as being contrary to God's will for our lives. I do not disagree with that. They still allow those more moderate ones like myself to be in their group. They have asked me to represent them today not because of my stance on abortion, but because of my role in medical education and my view on current ACGME guidelines. In twenty years of

medical practice, mostly in a university setting or in Africa. I have done over two dozen pregnancy terminations for threat of life to the mother, lethal fetal anomalies, or rape and incest. I have worn many hats during these years, all of which have influence my thoughts on abortion.
I, like most other Americans, understand the futility associated with the abortion issue. Political extremists have made this one of the most controversial and distasteful subjects in America for most of us who attempt to practice obstetrics and gynecology. I am appalled at the violence advocated by some prolife supporters, and cannot support their lack of compassion for women in some settings. I am no less appalled by pro-choice supporters at times, as well. There will be no answer that pleases all, or even a majority, on most abortion-related issues. It is not a topic I normally discuss in public. I have published over 25 articles and chapters on issues in biomedical ethics, but very few of these are related to abortion. It is with reluctance, but a sense of duty that I speak to you today.

As Americans and an obstetrician gynecologists, we have never lost our respect for individual liberties. We protect and defend our patients' rights to confidentiality and pursuit of reasonable health care within a healthy lifestyle. My own thoughts were very pro-choice 25 years ago, and I openly work with pro-choice physicians, who I deeply respect. They also readily work with me.

For over four years out of the last twenty, however, I have worked in rural West Africa, where beneficence, justice, pragmatism, and survival are overwhelming ethical norms. . . .loss of individual liberties and protection of women's rights are of little interest. It is a place where something called famine and starvation become reasons for amniotic fluid infections and medically indicated mid-trimester terminations to save the mother's life, by a procedure called a dilatation and evacuation. It requires breaking up the fetus in-utero and removing it in pieces then reassembling the body parts on a table to make sure the procedure has been completed. It does not take too many of these procedures to dampen one's enthusiasm for elective abortion.

For the past 9 years, I have been the grant funded external coordinator for OB-GYN training in Ghana, West Africa. We have decentralized medical care from the university and stopped the drain of physicians to the western world, creating community-based obstetricians and gynecologists

who are both excellent and relevant in their part of the world. These doctors have already made a difference in maternal mortality rates--something all of the billions of dollars in U.S. aid for family planning had failed to do over the past 20 years.

Yet, when we approached America's U.S. AID office for support in 1993, in Ghana, we found the doors closed unless we were asking for money to promote family planning or abortion. Forty million dollars were labeled for maternal health in Ghana, but it went to support a pro-abortion, family planning organization in New York, while the projects requested by Ghanaian OB-GYN professors and planners went unfunded. While we spend billions in America for invitro fertilization, we undermind proven ways to provide safe reproduction in the third world where having children is so highly valued in order to pursue our own family planning policies. In our zeal to express our own values, we have gone a step too far.

For 9 of the last 15 years, I served on the board of directors for the National Down Syndrome Congress. I have seen us, as a country, go into terribly emotional debates on whether or not to protect or condemn the handicapped "Baby Doe's" in our nurseries. Those within the pro-choice community have carried the battle from the incubator to the womb; we now, in 1994, have mandated a triple-screen for pregnant women of all ages, so that every woman carrying a fetus with Down syndrome may be given the choice to terminate that pregnancy. Such an effort will cost us over $1 billion in the coming year and will result in the wholesale elimination of the majority of what has come to be one of the kindest, most gentle and most progressive groups of people in America. Again, by attacking a non-lethal fetal anomaly in-utero, we appear to have gone a step too far. As one feminist writer has noted, the societal zeal to identify the "abnormal" in-utero has almost made it too unreasonable for a woman to choose to keep that "different child" that may even become the teacher of grace and humility in our lives.

Now in 1995, the pro-choice community has carried the implementation of their own values and view points into the arena of medical education. In the opinion of this obstetrician gynecologists they have again, inappropriately, gone a step too far. One must ask why the constant pushing on the part of one extreme side toward another has to continue, for both sides. As violent, harsh rhetoric mounts on all extremes, why should either side continue to scheme and plot to have their agenda

become triumphant. The immediate goals of the pro-choice community in this situation are obvious:

1) To attempt to force every residency training program to begin a free standing abortion clinic that would accommodate those seeking pregnancy termination on demand.

(Many would say that this would solve a serious access problem in our country for abortion services.)

2) To attempt to force every resident to have hands on training in the performance of pregnancy termination, unless a statement is signed professing moral or religious objections to abortion in general.

(Many would say this is to insure that all doctors are well trained to perform abortions in our society.)

3) To make abortion training a part of main line, standardized, and routine care. This would change its current image for many.

For a moment let's look at the validity of these goals.

(1) It is difficult for me to understand how we can claim an access to care problem, when some abortion clinics will not even allow a 24 hour delay between being seen in clinic and having the procedure done. I come from a state where Medicaid and indigent patients over age 45 do not even have access to public health clinics for pap smears or mammograms except at university centers, and no "access to care" cries are heard.

No lines exist awaiting abortions at any clinic providing pregnancy terminations across the state. Patients wait for 120 days to get into a gynecology clinic at my center, and 90+ days for an initial prenatal clinic visit, but these are not considered access problems, either.

(2) What about the argument that this will insure adequate expertise for abortions being done? At present, residents learn to do D & C's by the

dozens, and even dilatations and evacuations as a result of managing spontaneous pregnancy losses.

Abortion clinics all over America are run safely by doctors who had no special abortion training beyond that given in routine OB-GYN residencies. Training is more than adequate for the mechanical aspects of abortion technique with the management of natural pregnancy losses. The worry about quality of services seems, at best, to be contrived and imagined. (3) It does seem very obvious that this is a push to make abortion seem to be just a routine part of OB-GYN care--just something so ethically reasonable and justifiable that every person should expect to provide these services, at least during residency. An abortion simply is not a routine case for most of us in OB-GYN. It is special because human life is involved; not because the procedure is so "special." The fetus is not just another routine piece of tissue that presents itself for excision or removal with all expediency once it is deemed bothersome. Abortion is also a procedure with vast potential for later regret, as well as for medical complications that increase rapidly as the second trimester is entered. It is truly a "life lost," and for most of us, life is our most precious possession. To equate it to routine care, is to cheapen and demean many of our principles that relate to our respect for life from its inception to the point of death.

What is not protected in this ACGME mandate is for the reasonable physician to act autonomously in terms of abortion. For example, must a physician feel that he/she never should do an abortion, for any reason, if he/she has signed that they refuse to do them on religious or moral grounds? Can they still manage the patient they choose to assist with a pregnancy termination, without fear of increased liability that would result from "incomplete" training? Having established an elective exactly like the one now mandated by the ACGME at a prior university, I can see this as a coming problem. Not a single resident took the elective abortion experience in seven years, and I see no eager residents lining up to do this in our program now. However, any resident who would not help any patient with an abortion complication would be fired in our program, and many residents would do abortions for carefully selected reasons. Physician conscience, individual choice and medical discernment are simply ignored by any mandate such as this one by the ACGME. It is again a step too far.

The ACGME mandate is also in direct violation of existing legislation in many states. To comply with the new requirements would require us to sanction criminal activity in our state.

In short, the ACGME mandate is a thinly-veiled political maneuver that has little, if any, medical or ethical basis. Such politicalization of medical practice is potentially very dangerous for health care in America. What will happen next as a result of someone's political agenda? Will only those willing to do abortions be allowed to become OB-GYN specialists? Will the abortion ethic of the mechanical "I demand--You provide!" become the norm for all medical decision making in the future, as doctors become more and more technicians, while the concept of "medical indications" drifts off into the sunset. Ultimately patients and our society will suffer in such a system, and much of education will become meaningless.

It is, in my opinion, a time for America to re-group and re-think its position on such critical issues as abortion. Forcing others, subtly, through legislation or organizational mandate; or overtly, through fearful rhetoric and violence, are not acceptable ways to deal with difficult medical issues. All extreme opinions become unacceptable in such discussions. Individual freedoms, for all involved, must be respected, and the politicalization of health care issues must simply be discontinued as much as possible. The universal language of pain, suffering, and compassionate response is not a vocabulary of political power; and medicine must not be allowed to overcome a tool to that end. We once discussed strategies to reduce the number of abortions in or country, rather than watch both extremes fight one another in all kinds of ways. It is time to re-trace our steps.... and our thoughts.

CHRISTIAN MEDICAL & DENTAL SOCIETY

P.O. Box 5 • Bristol, TN 37621 • Ph: (615) 844-1000 • FAX: (615) 844-1005

Fax Cover Sheet

To Thomas Elkins, MD
Sent June 13, 1996 @ 4:08 PM
3 pp
From Jonathan Imbody
Director of Advancement

Information you requested follows.

Abortion

1. We oppose the practice of abortion and urge the active development and employment of alternatives.

2. The practice of abortion is contrary to:

   - The revealed, written Word of God.
   - Respect for the sanctity of human life.
   - Traditional, historical, and Judeo-Christian medical ethics.

3. We believe that biblical Christianity affirms certain basic principles which dictate against interruption of human gestation; namely:

   - The ultimate sovereignty of a loving God, the Creator of all life.
   - The great value of human life transcending that of the quality of life.
   - The moral responsibility of human sexuality.

4. While we recognize the right of physicians and patients to follow the dictates of individual conscience before God, we affirm the final authority of Scripture, which teaches the sanctity of human life.

Approved by the CMDS House of Delegates
Passed with a vote of 59 for, 1 opposed, 1 abstention
May 4, 1981, San Diego, California

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Chairman HOEKSTRA. Thank you.
Dr. D'Alessandri.

STATEMENT OF ROBERT D'ALESSANDRI, M.D., CHAIR DESIGNATE, ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION; ACCOMPANIED BY JOHN GIENAPP

Dr. D'ALESSANDRI. Thank you very much, Mr. Chairman.

I hope you will allow me a few extra minutes since Mr. Gienapp will have no prepared remarks, and I will be speaking on behalf of the ACGME.

Chairman HOEKSTRA. I would hope like other panel members that you would stick close to the five minutes.

Dr. D'ALESSANDRI. I will stick close to that.

Chairman HOEKSTRA. I would prefer that, yes.

Dr. D'ALESSANDRI. Thank you.

Members of the committee, ladies and gentlemen, my name is Robert D'Alessandri. I am Vice President for Health Sciences and Dean of the School of Medicine, the Robert C. Byrd Health Sciences Center at West Virginia University in Morgantown, West Virginia. I am the Chair Designate of the Accreditation Council for Graduate Medical Education and am representing that organization which was invited to present testimony at this hearing.

With me today are John Gienapp, Executive Director of the ACGME, as well as Dr. Joel Polen, Professor of Obstetrics and Gynecology at Temple University and Vice Chair of the Residency Review Committee of Obstetrics and Gynecology.

The ACGME was established to develop the most effective means of evaluating graduate medical education programs and to promote the quality of graduate medical education so the public can be sure that physicians who train in these programs meet the highest medical standards.

The ACGME is the body responsible for establishing educational standards and evaluating and accrediting residency programs in the United States. Members of the Council of the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies, working in cooperation, volunteers from these organizations resolve critical issues concerning the training of physicians in residency programs throughout the Nation.

There are more than 7,400 residency programs in more than 1,000 institutions in the United States that the ACGME accredits. To assure that the more than 100,000 young physicians enrolled in these programs receive education and training that is consistent and of high quality, the ACGME regularly evaluates these programs, establishes common policies, and sets the standards for residency programs in 26 core areas and 64 more specialized areas.

Perhaps it would be helpful for me to describe the process we use to do all of this and give you an idea of who is involved in this process.

The ACGME carries out its work through a council of 26 individuals, 20 volunteers appointed by the member organizations I mentioned; a resident representative; a representative of the Federal Government designated by the Secretary of the Department of

Health and Human Services; two public members; and an individual representing the residency review committees.

Residency review committees are groups of physician educators in each of the 26 medical specialties who propose educational standards and evaluate residency programs in their specialty. On the residency review committees more than 200 distinguished physicians serve each year. These volunteers who participate on the residency review committees are key to the efficacy of the process.

Through their work we directly influence the quality of graduate medical education, the quality of health care institutions, and ultimately the quality of medicine in America.

Each of the 7,400 residency programs in the United States is evaluated by the appropriate residency review committee on average every three and a half years. The program submits statistical and narrative information describing every aspect of the program, from curriculum content to on-call hours, for scrutiny by the residency review committee.

Then an on-site review is conducted. Based on the material prepared by the program and the report of the on-site visitor, the relevant residency review committee makes an accreditation determination. During the past year, ACGME committees made over 2,600 evaluation decisions.

The standards by which these programs are reviewed and are examined are examined and revised every five years to make sure they are specific about educational goals and allow for new medical knowledge and practices. Again, the goal of the standards is to assure the public is protected by high quality educational standards which are consistently applied.

As a part of this process, the standards for obstetrics and gynecology came under periodic review about two years ago. In May of 1993, the residency review committee for obstetrics and gynecology began the process of discussion, consultation, and drafting revised standards in obstetrics and gynecology.

In July 1993, at a retreat for all program directors of obstetrics and gynecology programs nationally, discussion groups were held on the educational standards that included education in family planning.

That fall, the draft of the proposed requirements was circulated to the American Board of Obstetrics and Gynecology, the American College of Obstetricians and Gynecologists, and the American Medical Association, to the member organizations, the AAMC, the CMSS, and the ABMS, and to all program directors for comment.

Comments were received and discussed by the residency review committee, and proposed changes were once again widely distributed to all program directors for comment.

In January of this year, the residency review committee prepared a final draft of the standards to submit to the ACGME for approval. At its February meeting, the ACGME approved the standards.

Although the previous educational standard which required clinical experience in family planning had been understood by the residency review committee to include education in the techniques of abortion, this understanding had not been stated explicitly and had

been challenged. The standard adopted in February clarified the expectation for education.

The language of the standard clearly exempts individuals who have a moral or religious objection to abortion, who will presumably not be performing these operations during the course of their medical career.

Likewise, institutions which offer residency education in obstetrics and gynecology where there is a religious, moral, or legal restriction are not required to change their practice. The language has been drafted to assure that physicians who may perform this legal procedure can learn to do so.

It is the opinion of the obstetricians serving on the residency review committee for obstetrics and gynecology and the medical organizations that reviewed and approved these standards and the over 280 program directors of obstetrics and gynecology that specific training is necessary in order to perform abortions safely and to protect the public health.

The ACGME developed this standard to provide the least burdensome method to assure that physicians are well trained and the public is well served. After the adoption of this standard, the ACGME received comment from some members of the Catholic Health Association to the effect that there was still a burden placed on some institutions. In an attempt to discuss their concerns fully, the ACGME recently met with representatives of the Catholic Health Association.

As a result of this meeting, the ACGME has now made modifications to the language in the standard as it applies to institutions with objections to abortions. Copies of the new standard, revised yesterday at its regular meeting of the ACGME, have been provided to you.

According to the new language, the programs will not be required to establish any mechanism to insure that residents have access to abortion training at other facilities. Instead, the standard will be that they may not impede residents in their programs who do not have moral or religious objections to abortions from receiving such education and experience elsewhere.

They will also be required to publicize their policy with respect to abortion training to all applicants.

As with all of our standards and with our evaluations of residency programs, the assurance of a quality education that will best serve the student, the resident, and the public is our goal.

Thank you very much for inviting the ACGME to provide testimony at this hearing. I'll be happy to answer your questions.

[The prepared statement of Dr. D'Alessandri follows:]

ACGME

Accreditation Council for Graduate Medical Education

Members of the Committee, Ladies and Gentlemen:

My name is Robert D'Alessandri. I am Vice President for Health Sciences and Dean of the School of Medicine, Robert C. Byrd Health Sciences Center at West Virginia University, Morgantown, West Virginia. I am Chair Designate of the Accreditation Council for Graduate Medical Education and am representing that organization, which was invited to present testimony at this hearing. With me is John Gienapp, Executive Director of the ACGME.

The Accreditation Council for Graduate Medical Education was established to develop the most effective means of evaluating graduate medical education programs and to promote the quality of graduate medical education so that the public can be sure that physicians who train in these programs meet the highest medical standards. The ACGME is the body responsible for establishing educational standards and evaluating and accrediting residency programs in the United States.

Member Organizations

American Board of Medical Specialties

American Hospital Association

American Medical Association

Association of American Medical Colleges

Council of Medical Specialty Societies

Members of the Council are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. Working in cooperation

volunteers from these organizations resolve critical issues concerning the training of physicians in residency programs throughout the nation.

There are more than 7400 residency programs in more than 1000 institutions in the United States that the ACGME accredits. To assure that the more than 100,000 young physicians enrolled in these programs receive education and training that is consistent and of high quality the ACGME regularly evaluates these programs, establishes common policies, and sets the standards for residency programs in 26 core areas and 64 more specialized areas.

Perhaps it would be helpful for me to describe the process we use to do all this and give you an idea of who is involved in this process.

The ACGME carries out its work through a council of 26 individuals, 20 volunteers appointed by its member organizations; a resident physician; a representative of the federal government, designated by the Secretary of the Department of Health and Human Services; two public members; and an individual representing the Residency Review Committees. Residency Review Committees are groups of physician educators in each of the 26 medical specialties who propose educational standards and evaluate residency programs in their specialty. On Residency Review Committees more than two hundred distinguished physicians serve each year. These volunteers, who participate on the Residency Review Committees, are

key to the efficacy of the process. Through their work, we directly influence the quality of graduate medical education, the quality of healthcare institutions and, ultimately, the quality of medicine in America.

Each of the 7400 residency programs in the United States is evaluated by the appropriate Residency Review Committee on average every three and one-half years. The program submits statistical and narrative information describing every aspect of the program--from curriculum content to on-call hours--for scrutiny by the Residency Review Committee. Then an on-site review is conducted. Based on the material prepared by the program and the report of the on-site visitor, the relevant Residency Review Committee makes an accreditation determination. During the past year ACGME committees made more than 2600 evaluation decisions.

The standards by which these programs are reviewed are examined and revised at least every five years to make sure they are specific about educational goals and allow for new medical knowledge and practices. Again, the goal of the standards is to assure that the public is protected by high quality educational standards which are consistently applied. As part of this process the standards for obstetrics and gynecology came under periodic review about two years ago.

In May of 1993 the Residency Review Committee for Obstetrics and Gynecology

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began the process of discussion, consultation and drafting revised standards in obstetrics and gynecology. In July 1993 at a retreat for all program directors of obstetrics and gynecology programs nationally, discussion groups were held on the educational standards that included education in family planning. That fall the draft of proposed requirements was circulated to the American Board of Obstetrics and Gynecology, the American College of Obstetricians and Gynecologists, and the American Medical Association, to the member organizations of the ACGME, and to all program directors for comment. Comments were received and discussed by the Residency Review Committee, and proposed changes were once again widely distributed to all program directors for comment. In January of this year the Residency Review Committee prepared a final draft of the standards to submit to the ACGME for approval. At its February meeting the ACGME approved the standards.

Although the previous educational standard, which required "clinical experience in family planning," had been understood by the Residency Review Committee to include education in the techniques of abortion, this understanding had not been stated explicitly and was challenged. The recently adopted standard clarifies the expectation for education.

The standard provides as follows:

"Experience with induced abortion must be part of residency training, except for

residents with moral or religious objections. This education can be provided outside the institution. Experience with management of complications of abortions must be provided to all residents. If a residency program has a religious, moral or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs must have mechanisms which ensure that residents in their programs who do not have religious or moral objection receive education and experience in performing abortion at another institution."

The language of the standard clearly exempts individuals who have a moral or religious objection to abortion- who will presumably not be performing these operations during the course of their medical career. Likewise, institutions which offer residency education in obstetrics and gynecology where there is a religious, moral or legal restriction are not required to change their practice. The language has been drafted to assure that physicians who may perform this legal procedure can learn to do so.

It is the opinion of the obstetricians serving on the Residency Review Committee for Obstetrics and Gynecology and the medical organizations that reviewed and approved these standards that specific training is necessary in order to perform abortions safely and protect the public health. The ACGME developed this

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standard to provide the least burdensome method to assure that physicians are well trained and the public is served.

Since the adoption of this standard the ACGME has received further comments from some members of the Catholic Health Association to the effect that there is still a burden placed on some institutions. In an attempt to discuss their concerns fully the ACGME recently met with representatives of the Catholic Health Association. As a result of this meeting, the ACGME is making further modifications of the language in the standard.

As with all our standards, and with our evaluations of residency programs, the assurance of a quality education that will best serve the public is our goal. Thank you very much for inviting the ACGME to provide testimony at this hearing. I will be happy to answer any questions you may have.

Chairman HOEKSTRA. Thank you.
Dr. Hannigan.

STATEMENT OF EDWARD V. HANNIGAN, M.D., DIRECTOR OF THE DIVISION OF GYNECOLOGIC ONCOLOGY, UNIVERSITY OF TEXAS AT GALVESTON

Dr. HANNIGAN. Chairman Hoekstra, Mr. Sawyer, Members of the subcommittee, my name is Edward Hannigan. I am Professor and Vice Chairman of the Department of Obstetrics and Gynecology at the University of Texas Medical Branch at Galveston. I am actively involved in my university's medical student residency education programs. I have served as Residency Program Director.

I would like to thank this committee for allowing me to participate in this important review of recent changes made in the program requirements for residency training in obstetrics and gynecology.

After the new requirements adopted by the ACGME become effective January 1, hands-on experience with elective abortion will be a required component of approved residence training programs. Under current guidelines, a program may fulfill its requirement to provide exposure to abortion by providing residents with exposure to patients being treated for spontaneous, incomplete abortions, or missed abortions.

The new requirements require involvement with induced abortion. Although an individual trainee may invoke moral grounds to excuse himself from participating, programs and program directors may not. Contrary to what we have just heard as a requirement of certification, they would be required to make such training available.

These changes in program requirements were not enacted to correct any education void. The basis of the technical skills involved in performing an abortion, that is, the use of a suction curette to evacuate a uterus, is a common part of current training programs.

There is no educational agenda in these changed requirements. There is only a political agenda. The number of obstetricians and gynecologists in the United States willing to perform an elective abortion is declining. The causes of the so-called abortionist shortage are multi-factorial and complex, and I would be glad to address this issue later if asked by the committee, but I assure you lack of curettement skills is not the cause of the shortages.

These changes in our residency training requirements were not intended to remedy some great educational deficiency, but to try to rehabilitate the abortionist's image and make all resident trainees active participants in performing elective abortions.

I repeat there is no educational agenda in these changed requirements. There is only an attempt to enforce attitudinal changes in OB–GYN trainees and programs.

The political motivation is a matter of public record. In the papers referenced at the end of my written statement, the clearly stated intention of those supporting changes in residency curriculum is to attempt to disseminate abortion services and rehabilitate the image of the abortionist. The intent openly stated is to make sure all trainees have bloodied their hands during training in the

hope they will lose their reluctance to make this procedure a part of their clinical practice.

Dr. David Grimes, an official of the American College of Obstetrics and Gynecology, in a January 1995 address in Washington, said, "Making abortion training a routine part of any residency will put abortion back in the mainstream of medicine."

We in Texas have made the decision in the mid–1970s not to include elective abortion as part of our residency curriculum. This decision was based upon several factors associated with the Pregnancy Interruption Clinic which was running at the time.

First, the clinic was a money loser. Almost all of the expenses of the clinic were underwritten by faculty professional income. This faculty income was used without regard to the moral concerns of the individual faculty members who had generated the income.

But the second problem was more significant and involved faculty, resident and staff morale. Individuals morally opposed to performing abortions were not required to participate. This led to the perception by trainees performing abortions they were carrying a heavier clinical load than the trainees not performing abortions. This perceived maldistribution of work became a significant morale issue. These morale problems spilled over to nursing and clerical personnel with strong feelings about abortions.

Because of bad feelings engendered by a program that was a financial drain, this clinic was closed. Now, regardless of our reason, the failure to teach the technique of elective abortion has never been a factor in the approval of our program by an accrediting agency.

I understand that when these changes become effective I would never be forced to participate in the performance of an abortion, but I am distressed that to keep my job, I would be forced to cooperate in an educational mission that advances these objectives. How could a pro-life physician ever become a program director if he is required to teach this curriculum? How could any Catholic hospital support a training program, even if its trainees went elsewhere to obtain the skills? Shouldn't program directors have freedom of choice to decide if a morally controversial area is included in their program? Where does a pro-life medical student obtain training in abortion pre-environment?

There is appropriate concern, as Mr. Sawyer indicated in his opening remarks, about this committee or any government body involving itself with the content of medical education curriculum. In almost all cases, I would agree that government should never micromanage the educational content of a medical training program.

But this is not an educational issue. This is a political issue, and political solutions are appropriate. We all agree that the use of elective abortion for the termination of a living pregnancy is one of the most divisive issues in our society. There is no one here who has not thought at length about the morality and ethics of elective abortion.

I doubt that anything I say will change the views on abortion of anyone in this room, but I can see that individuals acting in good faith can have deeply felt polar views. Current obstetrics and gynecology training rules have allowed sufficient flexibility for the

trainees, faculty members, and program sponsors to all accommodate themselves to its requirements.

The new requirements are a politically inspired, coercive attempt to change this equilibrium.

I sincerely thank you for your attention.

[The prepared statement of Dr. Hannigan follows:]

The University of Texas Medical Branch at Galveston

Remarks to be delivered to the Subcommittee on Oversight and Investigations on June 14, 1995 by Edward V. Hannigan, M.D.

Chairman Hoekstra, Members of the Subcommittee, and staff:

My name is Edward Hannigan. I am a Professor and Vice Chairman for Clinical Affairs of the Department of Obstetrics and Gynecology at the University of Texas Medical Branch at Galveston. At my university I am actively involved in both our medical student and residency education programs. I have served as Residency Program Director. I would like to thank this committee for allowing me to participate in this important review of recent changes made in the *Program Requirements For Residency Training in Obstetrics and Gynecology* (1).

The Residency Review Committee for Obstetrics-Gynecology has recently redrafted the document outlining requirements for an approved residency training program in Obstetrics and Gynecology. These changes have significantly expanded the required scope of training and the degree of resident involvement in induced abortion.

In February, these requirements were adopted by the Accreditation Council for Graduate Medical Education (ACGME) for use in evaluating and accrediting residency programs in my specialty. These Program Requirements become effective January 1, 1996.

After that time, "hands on" experience with elective abortion will be a required component of an approved residency training program in obstetrics and gynecology. Under current guidelines, a program may fulfill its requirement to provide exposure to abortion by providing residents with exposure to patients being treated for spontaneous incomplete abortions or missed abortions. The new requirements require involvement with induced abortion. Although an individual trainee may invoke moral grounds to excuse himself from participating, no approved program, or program director, may excuse themselves. As a requirement of certification, they are required to make such training available.

These changes in Program Requirements were not enacted to correct an educational void. As noted earlier, the basis of the technical skills involved in performing an abortion, i.e., the use of a suction curette to evacuate a pregnant uterus, is a common part of current training programs used to treat women with spontaneous abortions. Unfortunately, exposure to women with complications of induced abortion is also common. **There is no educational agenda in these changed requirements; there is only a political agenda.**

The number of obstetricians-gynecologists in the United States willing to perform an elective abortion is declining. The existance of this "abortionist-shortage" is acknowledged by individuals

regardless of their views on the role of elective abortion in our society. Indeed, in my part of the country, the shortage of abortionists is beginning to limit availability of services. The causes of the "abortionist-shortage" are multifactoral and complex, and I would be glad to address this issue later if asked by the committee. But, I assure you, lack of "curettement skills" is not the cause of this shortage. Changes in our residency training requirements were not intended to remedy some great educational deficiency, but to try to rehabilitate the abortionist's image and to make all resident trainees active participants in the preforming an elective abortion. I repeat, there is no educational agenda in these changed requirements; there is only a political agenda

The political motivation behind these changes is a matter of public record. In the appended references (2,3,4), the clearly stated intention of those supporting changes in the residency curriculum is to attempt to disseminate abortion services and rehabilitate the image of the abortionist. The mandate that a resident trainee participate in elective abortions, and in most programs the requirement to actually preform elective abortions, is not intended to broaden the resident's surgical skills, but rather to make the resident a participant in the abortion process. The intent, openly stated, is to make sure all trainees have bloodied their hands during training, in the hope that they will lose their reluctance to make this procedure a part of their clinical practice.

To further examine the claim that resident trainees are inadequately prepared for the surgical aspects of the abortion procedure, consider the paradoxical proposals that abortion services be provided by mid level providers, i.e., physician assistants or certified nurse

practitioners(5). You can't have it both ways. One can't argue that the procedure is so sophisticated that additional surgical training is required for spectalist physicians, but the procedure can be easily preformed by mid level providers. I agree that there is a learning curve to the safe performance of a suction curettage on a woman with a viable intact pregnancy, but these curettage skills are rapidly acquired, and current training programs provide a solid basis for these surgical procedures.

There is appropriate concern about this committee, or any government body, involving itself with the content of a medical education curriculum. In almost all cases I would agree that the government should never micromanage educational content of medical training programs. But this is not an educational issue: this is a political issue and political solutions are absolutely appropriate.

My concerns are both personal and global. I am a faculty member of a residency training program. Our program made a decision in the mid 1970's not to teach elective abortion as part of our curriculum. This decision was based on economic rather than moral issues. Regardless of our reason, the failure to teach the technique of elective abortion has never been a factor in the approval of our program by an accrediting agency. I understand that if the proposed changes become effective, I would never be forced to participate in the performance of abortion; but I am distressed that, to keep my current job, I would be forced to cooperate in an educational mission that espouses these objectives. To me, a "non-combatant" working to advance amoral objectives bears significant culpability. How could a pro-life physician ever become a Program Director if required to teach this curriculum? How could any Catholic

hospital support such a training program, even if its trainees went elsewhere to obtain the skills? Shouldn't program directors have freedom of choice to decide if a morally controversial area is included in their program? Where does a pro life medical student obtain training in an abortion free environment?

I am also concerned about the future direction of a specialty I love. Almost all of us who entered obstetrics and gynecology did so in a sense of awe involving the birth process. We are a self selected group. The new requirements may fundamentally change the way our specialty will be viewed by medical students making career choices. Whether consciously or subconsciously, pro life students will eliminate this as a career option early in their training. They will recognize that they can never be an abortionist, preform an abortion in training, or wish to be associated with a program heavily involved in terminating pregnancies. The will simply enter some other specialty. This change in residency requirements will effect the fundamental nature of our specialty.

We all agree that the use of elective abortion for termination of a living pregnancy is one of the most divisive issues in our society. There is no one here who hasn't thought at length about the morality and ethics of elective abortion. I concede that individuals, acting in good faith, can have deeply felt polar views. Current obstetrics and gynecology training rules have allowed sufficient flexibility so that trainees, faculty members, and program sponsors can all accommodate themselves to its requirements. The new requirements are a politically inspired coercive attempt to push this equilibrium to the left.

5

Hannican
June 14,1995

I sincerely thank you for you attention

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1. Program Requirements in Residency Training in Obstetrics and Gynecology. Accreditation Council for Graduate Medical Education. Chicago. 1995

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3. Grimes, D. A., Clinicians Who Provide Abortions: The Thinning Ranks, *Obstet Gynecol* 80: 719-723, 1992

4. Westhoff, C., Abortion Training in Residency Programs, *JAMWA* 49:150-152, 1994

5. Vermont Physician Assistants Perform Abortions, Train Residents, Fam Plann Perspect, 24: 225, 1992

Chairman HOEKSTRA. Thank you.
Dr. Ling.

STATEMENT OF FRANK W. LING, M.D., FELLOW, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Dr. LING. Good afternoon. I am Frank W. Ling, a practicing obstetrician-gynecologist, and I am pleased to testify on behalf of the American College of Obstetricians and Gynecologists. I am also Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Tennessee, Memphis.

As an organization committed to assuring that women's health care meets the highest standard, ACOG supports the ACGME abortion training requirement. Abortions are a legal medical procedure, and the safety of the patient is our paramount concern. Training in induced abortion is necessary to prepare doctors for a variety of complications in situations that will arise in their career. This training is a benefit whether or not abortions are performed as a part of their practice.

For example, having knowledge of abortion techniques allows the physician to answer questions his or her patient may raise and provide better counseling. Furthermore, while training the management of complications of abortion is critical, it cannot replace training in induced abortion. Every day in the real world doctors are faced with complicated procedures. The outcomes are often the difference between life or death, depending on the experience and training of that physician.

Some real world examples may demonstrate my point. For example, an 18 year old girl in rural America with cystic fibrosis in her second trimester of pregnancy; due to her cystic fibrosis, she suffers acute respiratory compromise and termination of the pregnancy is necessary to save her life. There is only one physician who is adequately trained to perform this procedure within a 100 mile radius.

As a second example, a 25 year old woman who suffers massive internal injuries in a car accident that has resulted in the death of her 18 to 20 week fetus. She arrives in the emergency room, and the OB–GYN on call has not been trained in abortion. The delay while searching for a physician trained in various techniques could result in significant deterioration of the woman's health and possibly death.

A third example, the woman who receives her first prenatal care visit at 18 to 20 weeks of pregnancy. Her ultrasound reveals that the fetus has anencephaly, the incomplete formation of the brain and head that is incompatible with life. After making the wrenching decision to abort her fetus, there is no doctor within 250 miles who is able to perform the abortion. She must wait at least a week for the surgery if she can arrange transportation to the provider who can do the procedure.

These are just three specific scenarios that one of my colleagues faced in just the last year. From these examples, you can imagine the large numbers of dilemmas women face that OB–GYNs must address on a national level.

Lack of training in induced abortion in any of these situations could result in very serious medical consequences for women who

rely on OB–GYNs to provide skilled treatment, treatment that may, in fact, save their lives.

You have heard about the ACGME requirements. I would like to emphasize three points.

Number one, the requirements have undergone serious scrutiny from physicians experienced in medical education who have in their best medical judgment found abortion training to be appropriate and necessary for OB–GYN residents. Not only were these discussions part of the ACGME process, but the requirements were also discussed in the ACOG forums throughout and around the country.

Point number two, continuing negotiations to improve the language are ongoing, and we have the results of those today. ACOG is supportive of these efforts and believes that they offer the best opportunity for resolution in recognizing individual and institutional concerns on this very volatile issue.

Number three, congressional override of the ACGME requirements would represent an unprecedented involvement in the private educational accreditation process. Never before has an override of any educational standards been proposed. The consequences of such intrusion are not insignificant. Quite frankly, Congress is simply not equipped to make decisions about what is or is not appropriate medical care and training any more than I am qualified to dictate the rules of this committee.

I urge the committee to reject any such proposal. Notwithstanding the importance of adequate training in abortion techniques, ACOG believes that physicians must retain the right to make choices about their own practice. Many well respected leaders in the college, like Dr. Elkins and others, have chosen not to perform abortions because of their own personal views. Accordingly, we support the ACGME provisions that exempt residents and institutions who oppose the training on moral, legal, or religious grounds.

However, it is ACOG's position that appropriate exposure to and training in abortion techniques must be the rule, while exemptions for those who choose not to participate must be the exception.

I appreciate the opportunity to testify today, and I will be happy to answer any questions committee members may have.

[The prepared statement of Dr. Ling follows:]

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Good afternoon, I am Frank W. Ling, MD, a practicing obstetrician-gynecologist and Professor and Chairman of the Department of Obstetrics and Gynecology at the University of Tennessee, Memphis. On behalf of the American College of Obstetricians and Gynecologists (ACOG), I am pleased to testify in support of the Accreditation Council on Graduate Medical Education (ACGME) abortion training requirements for residents in obstetrics and gynecology. ACOG is a national organization representing more than 35,000 physicians dedicated to improving women's health care. I am a Fellow of ACOG and have worked on educational issues as a member on its Committee on Scientific Program, the Committee on Annual Clinical Meeting, and its Primary Care/Preventive Health Task Force. Currently, I am Chair of the Tennessee Section of ACOG. I also am a Council Member of the Council on Residency Education in Obstetrics and Gynecology (CREOG).

As an organization committed to assuring that women's health care meets the highest standard of medical care, ACOG supports the recently approved ACGME requirements proposed by its Residency Review Committee (RRC) on Obstetrics and Gynecology, including the requirements for training in induced abortion, except for those residents and institutions with religious, moral, or legal objections to abortion. We believe ob-gyns need to be well-trained in all aspects of women's health.

Abortions are a legal, medical procedure and the safety of the patient is our paramount

concern. Physicians need to be trained and prepared to handle a variety of complications and situations related to abortions, whether or not they personally preform them.

Having knowledge of abortion techniques allows a physician to answer questions his or her patient may raise. The answer to these questions may discourage a woman from having an abortion, or she may seek care from another provider, but she is entitled to the information to make an informed decision about her options and ob-gyns who women rely on for care need to be trained in how to provide counseling and information related to abortion.

Furthermore, while training in the management of complications of abortion is critical, it cannot serve as replacement for training in induced abortion. Changes that occur in a pregnant uterus present a more complicated situation for a doctor to manage. The technique and procedure of induced abortion is different and more complicated than a routine D and C or evacuating a uterus that has undergone a spontaneous abortion or a missed abortion. Every day, in the real world, doctors are faced with complicated procedures with the outcomes often being life or death, depending on the experience and training of that physician. Some of these real world scenarios include:

- an eighteen-year-old girl in rural America with cystic fibrosis in her second trimester of pregnancy. Due to her cystic fibrosis, she suffers acute respiratory compromise and termination of the pregnancy is necessary to save her life. There is only one physician who is adequately trained to perform this procedure within

an one-hundred-mile radius.

- the twenty-five-year-old woman who suffers massive internal injuries in a car accident that has resulted in the death of her twenty-three-week fetus. She arrives in the emergency room and the ob-gyn on call has not been trained in abortion. The delay while searching for a physician trained in various techniques of late trimester abortion could result in significant deterioration of the woman's health and, possibly, death.
- the woman who receives her first prenatal care visit at eighteen to twenty weeks of pregnancy. Her ultrasound reveals that the fetus has anencephaly -- the incomplete formation of the brain and head that is incompatible with life. After making the wrenching decision to abort her fetus, there is no doctor within two hundred and fifty miles who is able to perform the abortion, and she must wait a week for the surgery, if she can arrange transportation.

These are just three scenarios that any one of my colleagues may face in one year. Lack of training in induced abortion in any of these situations could result in very serious medical consequences for women who rely on ob-gyns to provide skilled treatment -- treatment that may in fact save their lives.

The ACGME requirements for residency programs in obstetrics and gynecology have been developed with the recognition that residents must receive training in the full range of health services available to women, including training in induced abortion. The exact language of the requirements reads,

Experience with induced abortion must be a part of residency education except for residents with moral or religious objections. This education can be provided outside the institution. Experience with management of complications for abortion must be provided to all residents. If a residency program has a religious, moral, or legal restriction which prohibits the residents from performing abortions within the institution, the program must ensure that the residents receive a satisfactory education and experience managing complications of abortion. Furthermore, such residency programs must have mechanisms which ensure that residents in their program who do not have religious or moral objections receive education and experience in performing abortions at another institution.

These requirements have undergone serious scrutiny from many respected physicians experienced in medical education who have, in their best medical judgment, found abortion training to be appropriate and necessary for ob-gyn residents. They were presented at multiple Council on Residency Education in Obstetrics and Gynecology (CREOG) program director meetings, numerous local ACOG meetings, and several ACOG Executive Board meetings. As the ACGME has testified, the revised training requirements were subject to a year of intense external review and public comment, during which all views were taken into consideration. The requirements were finalized in February, 1995, and are scheduled to go into effect in January, 1996.

Recognizing that there still remains legitimate concerns and questions about portions of the requirements from several institutions, it is appropriate for further discussions to take place between the accrediting body and those concerned institutions. ACOG supports those efforts and understands progress is being made. Clearly, all those directly involved in developing and implementing these requirements must work together to ensure that residency training is not compromised by controversy over this issue. However, ACOG does feel strongly that this process must remain free of legislative intrusion. Congressional override of the ACGME requirements would represent an unprecedented involvement in the private educational accreditation process. Never before has an override of educational standards been proposed and such a proposal represents an unwarranted intrusion into the ability of the medical profession to determine the appropriate level of training and education required for the practice of medicine. The implications of such an override are not insignificant. Congress is simply not equipped to make decisions about what is or is not appropriate medical care and training, and I urge this Committee to reject any such proposal.

Notwithstanding the importance of adequate training in abortion technique, ACOG believes that physicians must retain the right to make choices about their own practice. Many well-respected leaders in the College have chosen not to perform abortions because of their own personal views. Accordingly, we support the ACGME provisions that exempt from training those residents and institutions who oppose the training on moral, legal, or religious grounds. However, it is ACOG's position that appropriate training

in abortion techniques must be the standard of education, while exemptions for those individuals and institutions who choose not to participate must be the exception.

In conclusion, ACOG and the ACGME, as well as other medical institutions and organizations, are bound to ensuring that physicians have the education necessary to perform their duties as a physician, including the medical procedure of abortion. For these reasons, ACOG believes that the ACGME requirements on abortion training must be retained as long as abortion is a legal medical procedure in this country. I urge the Committee to reject any legislative attempts to override these requirements. Thank you for the opportunity to testify today. I would be happy to answer any questions Committee members may have.

Chairman HOEKSTRA. Thank you.
Dr. Levatino.

STATEMENT OF ANTHONY LEVATINO, M.D., J.D., ASSISTANT CLINICAL PROFESSOR, ALBANY MEDICAL CENTER OF OBSTETRICS AND GYNOCOLOGY

Dr. LEVATINO. Members of the committee, thank you for the opportunity to speak to you today concerning the recent adoption of new training guidelines by ACGME, the Accreditation Council of Graduate Medical Education.

My name is Anthony Paul Levatino. I graduated from Albany Medical College in Albany, New York, in 1976, and completed a four-year residency in obstetrics and gynecology in 1980. During those four years, I learned to perform first and second trimester abortions.

I entered private practice in 1980 and regularly performed abortions on patients who were up to 20 weeks pregnant. I stopped performing all abortions in 1985 and continued my private practice.

In 1993, I graduated from Albany Law School. Currently I am an Assistant Clinical Professor of Obstetrics and Gynecology at Albany Medical College, where I serve on the faculty. I am also of counsel to a Troy, New York, law firm which dedicates the majority of its efforts to medical malpractice defense of physicians and hospitals.

ACGME's mission is to identify and institute appropriate guidelines and oversight to insure quality resident medical education in approximately 26 medical specialties. Its highest and most noble purpose is to assure the public that residency program graduates possess the skills necessary to competently care for their patients, thereby enhancing public health and safety. Patient safety is clearly the primary goal.

When ACGME's mission is evaluated in this light, the new obstetric residency training guideline which mandates training in elective abortions makes no sense whatsoever. As I look at this particular new regulation and examine published statements made by members of ACGME and other proponents of this particular guideline, it is patently obvious to me that the only real purpose it serves is to attempt to increase the number of abortionists, a goal totally outside of ACGME's competence and concern.

No one questions that obstetricians who do perform abortions must be fully trained to perform them safely and effectively. Yet I have seen no evidence whatsoever that these guidelines were formulated in response to a documented increase in the number or severity of complications secondary to elective or induced abortions resulting from a lack of appropriate training of obstetrician-gynecologists.

In the April 15, 1995, issue of OB–GYN News, Dr. William Andrews, President of the American College of Obstetricians and Gynecologists, admitted that "the abortion training requirement was inserted in response to a perceived need," a perception that there is a shortage of physicians trained to do abortions. That perception, I submit, is faulty.

A major goal of most of the revised guidelines was to increase the amount of training obstetrical residents receive in primary care. The revisions taken as a whole serve that purpose well, but in

making abortion training mandatory, ACGME drafted a requirement which is expressly coercive in the case of institutions, many of which have longstanding prohibitions against performing or facilitating the performance of abortion.

By their nature, this guideline will also serve, in my opinion, to coerce individuals as well. Abortion is very different from all other medical procedures. The Supreme Court acknowledged this in Harris v. McRae in 1980. Only in the active abortion is a living, growing, health human being deliberately destroyed, yet these new guidelines mandate that experience with induced abortion must be part of the training of every OB–GYN resident. The sole exemption is for residents with moral or religious objections to abortion.

Private hospitals, even those with a religious affiliation, are not exempt. Obviously these comments were prepared before this revision.

Those institutions that are not willing or able to train residents to do abortions on site must insure that residents who have no objection are trained elsewhere. The penalty for noncompliance is loss of accreditation.

In promulgating such a requirement, the ACGME not only has the unusual distinction of being both anti-life and anti-choice at the same time, but has also mandated a requirement which flies in the face of both Federal law and the laws of a vast majority of States. Forty-one States currently confirm an express statutory right upon private hospitals to refuse to participate in abortions. Two other States, New York and West Virginia, confer such a right upon persons, a broader term that likely includes hospitals.

Thirty-three States have civil liability and/or disciplinary or other retaliatory action against private hospitals based on their refusal to perform abortions. These figures make clear that this ACGME guideline would conflict with explicit statutory safeguards in the vast majority of States.

These figures are actually conservative because they do not take into account those jurisdictions that may bar discriminatory treatment of hospitals that refuse to perform abortions on jurisprudential or constitutional grounds.

That ACGME's program requirements would permit abortions off site does not cure the defect or make them any less coercive. In at least 25 States, the relevant statutory language on its face is either plainly or arguably broad enough to exempt hospitals from indirect participation in abortions.

Federal law is also implicated. The Religious Freedom Restoration Act of 1993 prohibits Federal and State governments from substantially burdening the free exercise of religion unless the State can demonstrate that the law furthers a compelling governmental interest and is the least restrictive means of furthering that interest.

This would include State licensing and accrediting agencies, as well as entities to which licensing and accrediting functions are delegated by the State.

As the majority of States permit private hospitals to refuse to participate in abortions, it would be very difficult to successfully argue that the ACGME guidelines further a compelling governmental interest or do so by the least restrictive means. A case in

which a religious hospital was required to provide abortions was repeatedly cited in congressional testimony that led to the enactment of the Religious Freedom Restoration Act in the first place. Forcing religious hospitals to participate in abortions is precisely one situation the RFRA was intended to prevent.

It is my understanding that Congressman Hoekstra is considering the introduction of legislation designed to protect individuals and programs from discrimination based on a refusal to be trained, train, or arrange for training in the performance of abortions. In my opinion, such legislation is urgently needed.

Despite the consensus on policy of the vast majority of States, the kind of discrimination through accreditation standards that results from the ACGME abortion training requirement may well fall between the cracks of the law and not be effectively countered by existing laws for a number of reasons.

First, not all States have protective laws.

Two, not all laws protect residency programs, as well as individuals.

Three, not all laws protect against being forced to arrange abortion training at another physical location.

Four, there is not a consensus in the case law as to whether ACGME's own actions can be seen as State action. Consequently, some conscience clauses would not directly protect against ACGME requirements.

Five, there is very little case law clarifying the meaning and breadth of State conscience clause laws. So their application to the situation is uncertain.

In conclusion, this particular ACGME policy poses a new and insidious problem in governmental discrimination. Under the guise of educational accreditation standards, it imposes an ideological policy which State and Federal governments would then, however unwittingly, enforce by their traditional reliance on this organization for licensure and eligibility for Federal assistance. It is a new national problem that deserves Federal scrutiny and action.

Thank you.

[The prepared statement of Dr. Levatino follows:]

Anthony P. Levatino, M.D., J.D.

Ladies and gentlemen, thank you for the opportunity to speak to you today concerning the recent adoption of new training guidelines by the ACGME (Accreditation Council of Graduate Medical Education). My name is Anthony Paul Levatino. I graduated from Albany Medical College in Albany, New York in 1976 and completed a four-year residency in obstetrics and gynecology in 1980. During those four years I learned to perform first and second trimester abortions. I entered private practice in 1980 and regularly performed abortions on patients who were up to twenty weeks pregnant. I stopped performing all abortions in 1985 and continued my practice. In 1993, I graduated from Albany Law School in the top two percent of my class. Currently, I am an assistant clinical professor of obstetrics and gynecology at Albany Medical College where I serve on the faculty. I am also of counsel to a Troy, New York law firm which dedicates the majority of its efforts to medical malpractice defense of physicians and hospitals.

ACGME's mission is to identify and institute appropriate guidelines and oversight to ensure quality resident medical education in approximately twenty-six medical specialties. It's highest and most noble purpose is to assure the public that residency program graduates possess the skills necessary to competently care for their patients thereby enhancing public health and safety. Patient safety is clearly the primary goal. When ACGME's mission is evaluated in this light, the new obstetric residency training guidelines which mandate training in

elective abortion make no sense whatsoever.

As I look at this particular new regulation and examine published statements made by members of ACGME and other proponents of this particular guideline, it is patently obvious to me that the only real purpose it serves is to attempt to increase the number of abortionists - a goal totally outside of ACGME's competence and concern. No one questions that obstetricians who do perform abortions must be fully trained to perform them safely and effectively. Yet, I have seen NO evidence whatsoever that these guidelines were formulated in response to a documented increase in the number or severity of complications secondary to elective or induced abortion resulting from a lack of appropriate training of obstetrician-gynecologists. In the April 15, 1995 issue of *Ob-Gyn News*, Dr. William C. Andrews, president of the American College of Obstetricians and Gynecologists, admitted that "the abortion training requirement was inserted in response to a perceived need" - a perception that there is a shortage of physicians trained to do abortions. That perception, I submit, is faulty.

A major goal of most of the revised guidelines was to increase the amount of training obstetrical residents receive in primary care. The revisions taken as a whole serve this purpose well but in making abortion training mandatory, ACGME drafted a requirement which is expressly coercive in the case of institutions, many of which have longstanding prohibitions

against performing or facilitating the performance of abortions. By their nature, this guideline will also serve, in my opinion, to coerce individuals as well.

Abortion is very different from all other medical procedures. The Supreme Court acknowledged this in Harris v. McRae in 1980. Only in the act of abortion is a living, growing, healthy human being deliberately destroyed. Yet, these new guidelines mandate that experience with induced abortion must be part of the training of every Ob-Gyn resident. The sole exemption is for residents with moral or religious objections to abortion. Private hospitals, even those with religious affiliations, are not exempt. Those institutions that are not willing or able to train residents to do abortions on site must ensure that residents who have no objection are trained elsewhere. The penalty for noncompliance is loss of accreditation.

In promulgating such a requirement, the ACGME not only has the unusual distinction of being both anti-life and anti-choice at the same time but has also mandated a requirement which flies in the face of both federal law and the laws of a vast majority of states. Forty-one states currently confer an express statutory right upon private hospitals to refuse to participate in abortions. Two other states (New York and West Virginia) confer such a right upon "persons" - a broader term that likely includes hospitals. Thirty-three states bar civil liability

and/or disciplinary or other retaliatory action against private hospitals based on their refusal to perform abortions. These figures make clear that this ACGME's guideline would conflict with explicit statutory safeguards in the vast majority of states. These figures are actually conservative because they do not take into account those jurisdictions that may bar discriminatory treatment of hospitals that refuse to perform abortions on jurisprudential or constitutional grounds.

That ACGME's program requirements would permit abortions off-site does not cure the defect or make them any less coercive. In at least twenty-five states, the relevant statutory language on its face is either plainly or arguably broad enough to exempt hospitals from indirect participation in abortions.

Federal law is also implicated. The Religious Freedom Restoration Act of 1993 prohibits federal and state governments form substantially burdening the free exercise of religion unless the state can demonstrate that the law furthers a compelling governmental interest and is the least restrictive means of furthering that interest. This would include state licensing and accrediting agencies as well as entities to which licensing and accrediting functions are delegated by the state. As the majority of states permit private hospitals to refuse to participate in abortions, it would be very difficult to successfully argue that the ACGME guidelines further a compelling governmental interest or do so by the least restrictive means. A

case in which a religious hospital was required to provide abortions was repeatedly cited in Congressional testimony that led to the enactment of The Religious Freedom Restoration Act in the first instance. Forcing religious hospitals to participate in abortions is precisely one situation the RFRA was intended to prevent.

It is my understanding that Congressman Hoekstra is considering the introduction of legislation designed to protect individuals and programs from discrimination based on a refusal to be trained, train or arrange for training in the performance of abortions. In my opinion, such legislation is urgently needed. Despite the consensus on policy of the vast majority of states, the kind of discrimination through accreditation standards that results from the ACGME abortion training requirement may well fall between the cracks of the law and not be effectively countered by existing laws for a number of reasons.

1) Not all states have protective laws.

2) Not all laws protect residency programs as well as individuals.

3) Not all laws protect against being forced to arrange abortion training at other physical locations.

4) There is not a consensus in the case law as to whether ACGME's own actions can be seen as "state action". Consequently, some conscience clauses would not directly protect against ACGME requirements.

5) There is very little case law clarifying the meaning and breadth of state conscience clause laws, so their application to this situation is uncertain.

In conclusion, this particular ACGME policy poses a new and insidious problem in governmental discrimination. Under the guise of educational accreditation standards, it imposes an ideological policy which state and federal governments would then (however unwittingly) enforce by their traditional reliance on this organization for licensure and eligibility for federal assistance. It is a new national problem that deserves federal scrutiny and action.

Chairman HOEKSTRA. Thank you.
Dr. Smith.

STATEMENT OF PAMELA SMITH, M.D., DIRECTOR OF MEDICAL EDUCATION, MT. SINAI MEDICAL CENTER

Dr. SMITH. Thank you.

My name is Dr. Pamela Smith, and I am the President Elect of the American Association of Pro-Life Obstetricians and Gynecologists. It is this organization that I am officially representing today, but I also happen to be Director of Medical Education in the Department of Obstetrics and Gynecology in Mt. Sinai Hospital in Chicago, Illinois.

The recent ACGME ruling which mandates that all obstetrics and gynecology training programs provide abortion training for residents has nothing to do with education. It represents a brazen attempt by politically isolated leaders in organized medicine, in cooperation with the National Abortion Federation, to coerce individuals and institutions that are morally opposed to abortion into becoming intimately associated with abortion providers.

This ruling also promotes the false premise that all physicians within our society support abortion on demand as national policy when, in fact, there is both moral and medical division within the medical profession of the validity of such a practice.

The Supreme Court decision of Roe v. Wade has perhaps inadvertently created an environment in America where two stark human realities are competing against each other resulting in radically different health care agendas for complex medical-social problems. Indeed, it is the pitting of the needs of the mother against those of her unborn child that accounts for the continued divisiveness of the practice of abortion within our country at large, but perhaps more importantly, within the practice of the specialty of obstetrics and gynecology.

Although this fundamental conflict is painfully obvious, the proposed ACGME mandate completely ignores it, complaining instead that it is a lack of education and training that is responsible for a perceived need for abortion providers.

Nothing could be further from the truth. Mandated abortion training will not teach a single OB-GYN resident anything new. The surgical techniques that are utilized in the treatment of stillbirths and miscarriages are identical to the ones performed in elective abortions. The major difference is that abortion involves performing these procedures on a patient whose baby is still healthy and very much alive.

What mandated abortion training will succeed in doing, however, is to open the floodgates for pro-abortion propaganda campaigns to descend upon every residency training program in America, and although the mandate was for OB–GYN programs alone, family practice programs have been targeted and similarly inundated as well.

Mandated abortion training is not needed in order for those who support unrestricted abortion access to have opportunities to provide this type of training for those who desire it. Eighty-nine percent of current training programs offer optional experience with first trimester procedures, and 82 percent offer the same optional experience for second trimester.

Moonlighting opportunities currently exist for those residents who want to supplement their income by providing abortion services, and electives and fellowships can easily be developed to provide experiences for residents and fellows who desire further training, as well.

The nonrepresentative nature that characterizes the leadership in organized medicine, especially that in obstetrics and gynecology, coupled with the longstanding practice of actively discriminating against those with different philosophies is legendary and acknowledged in both the academic and community-based clinical practices of our specialty.

Although the members of the ACGME asserted they consulted the program directors in this initiative, as a member of the Association of Professors of Gynecology and Obstetrics who was present at the July 1992 retreat when the representatives of Region IV voted overwhelmingly to reject this proposal and to leave guidelines for abortion training as they currently existed intact, I can assure you that program director meetings are not exercises of representative democracy, but that of academic dictatorships. In fact, the recognition of this political reality is what led to the inclusion of the mandated abortion question in the nationwide survey that was conducted by my organization in the first place.

When the 37,000 OB–GYNs in this country were asked, 59 percent voted against mandated abortion training. The ACOG has gone on record as endorsing abortion as a part of national health insurance, although 55 percent of the OB–GYN community is against tax dollars being used for this purpose.

States whose citizens chose to pass pro-life legislation have been economically boycotted by the ACOG board, although 61 percent of OB–GYNs stated that ACOG should maintain either a neutral or pro-life position on the abortion issue.

It is also my understanding that the Medical Ethics Committee of the ACOG recommended that this proposal not be adopted as it clearly violates the moral conscience of institutions.

Furthermore, this policy violates ACOG's own policy statement on abortion which begins by stating, "The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected."

How can ACOG claim truly to believe in its own policy when an institution which has moral opposition to abortion must make arrangements with and provide malpractice insurance for every resident who desires training in an abortion clinic?

From a pro-life perspective, this is like sending a pre-born infant to a concentration camp, but then proclaiming you are innocent because you were just following orders and did not do the procedure yourself.

Although the leaders in academic OB–GYN are reticent to listen to or consult with the clinicians in this country who practice their trade, they readily receive and act on input given to them by representatives and supporters of the abortion industry.

In a 1992 article published in Obstetrics and Gynecology, Dr. David Grimes, in consultation with the National Abortion Federation, argues that abortion needs to be mainstreamed into all resi-

dency training programs and incentives devised to encourage doctors to do something that many of us find distasteful. He ends the article with a quote from another similarly minded physician who declares, "The medical profession must be educated to the fact that abortion is no longer a favor to bestow, but rather an obligation to perform."

It is no coincidence that within three years, the ACGME decided in the name of education to make the provision of abortion training mandated for all programs.

Finally, I would be remiss if I did not mention that there are negative medical consequences that are frequently suffered by women who submit themselves for abortion procedures. Physicians who categorically state that abortion is fundamental to comprehensive care for women, reproductive health, and economic freedom are apparently unaware of a statistical association between breast cancer and abortion.

Since this topic is not covered in the OB–GYN scientific literature, this may explain their ignorance, and clearly there would be no need for organizations such as Women Exploited by Abortion if post-abortion syndrome were not a reality.

In summary, the ACGME mandate has nothing to do with education. Every single obstetrician-gynecologist in this country knows how to do an abortion. The problem for abortion advocates is that most physicians refuse to use their skills in this form of service, and that this includes physicians who support the decriminalization of abortion.

This mandate has the clear purpose of mainstreaming abortion practice within the medical community and presenting to the American public the totally false impression that all physicians believe that abortion is just another medical procedure, when clearly it is not.

If ACGME is truly interested in providing educational opportunities for residents who desire abortion training, they should attempt to mobilize the 47 percent of the OB–GYN community that stated in the nationwide survey that they would support abortion as a measure of fertility control and confine their educational activities to institutions that share their moral values. They should not be allowed to use the power of accreditation, as Dr. David Grimes suggests, as an incentive to encourage doctors to do something that many of us find distasteful.

Thank you.

[The prepared statement of Dr. Smith follows:]

Summary of Testimony by Dr. Pamela Smith
House Education Subcommittee on Oversight and Investigations
June 14, 1995

The recent ruling by the Accreditation Council for Graduate Medical Education (ACGME) which mandates that all Ob/Gyn training programs provide abortion training for residents has nothing to do with education. Rather, it represents a brazen attempt by politically isolated leaders in organized medicine, in cooperation with the National Abortion Federation, to coerce individuals and institutions morally opposed to abortion to become intimately associated with abortion providers. The ruling promotes the false notion that all physicians within our society support a national policy of abortion on demand. In fact, there is both moral and medical division within the medical profession, and especially within the practice of the specialty of obstetrics and gynecology, as to the validity of this practice.

The ACGME mandate claims that it is a lack of education and training that is responsible for a perceived need for abortion providers. Nothing could be further from the truth. Mandated abortion training will not teach a single ob/gyn resident anything new. The surgical techniques that are utilized in the treatment of stillbirths and miscarriages are identical to the ones performed in elective abortions. The major difference is that abortion involves performing these procedures on a patient whose baby is still very much alive and healthy. What mandated abortion training will succeed in doing, however, is to open the floodgates for proabortion propaganda campaigns to descend upon every ob/gyn residency training program in America. Family practice programs have been targeted as well.

When 37,000 ob/gyns nationwide were surveyed, 59% voted against a policy of mandated abortion training. The Medical Ethics Committee of the American College of Obstetrics and Gynecology (ACOG) recommended that such a policy not be adopted. Mandated abortion training is clearly not needed as over 80% of all training programs offer optional experience with both first and second trimester procedures.

And mandated training violates ACOG s stated policy on the decision to provide abortion services by individual college members.

Statistics easily document that the leadership of the ACGME, and in academic Obstetrics and Gynecology, is reticient to listen to or consult with those ob/gyn doctors who practice the specialty and do the training. However, they readily receive and act upon input from representatives of the abortion industry. Dr. David Grimes has argued, in an article printed in the October 1992 edition of Obstetrics and Gynecology, that abortion needs to be mainstreamed into all residency programs and "incentives" devised to encourage doctors to do something that many of us find distasteful. And Dr. John Fishburne, in the February 1st edition of OBGYN News, is quoted as saying these requirements "carry a lot of weight" since "residents graduating from nonaccredited programs often have trouble getting hospital privileges and board certification"...

These statements reveal the true reason for a policy of forced abortion training: not education, but the fact that most physicians refuse to use their skills in this form of "service"...including physicians who strongly support the decriminilazation of abortion. Abortion advocates have therefore resorted to using a guise of education to force their views and practices on others who do not share them.

Prolife physicians and institutions recognize from the daily aspects of our practice that abortion is not only fatal to preborn children but it is also harmful to women and serves as a destructive force against the American family. The ACGME shuld not be allowed to use its power of accreditation as one of the "incentives" to coerce doctors to participate in a practice many of us find morally and professionally repugnant. Instead, it should restrict itself to promoting ideals that are truly educational in nature.

Testimony of Pamela Smith, MD
Director of Medical Education, Department of Obstetrics and Gynecology
Mt. Sinai Medical Center
Chicago, Illinois

Subject: Mandated Abortion Training in Ob/Gyn Residency Programs

House of Representatives
Committee on Economic and Educational Opportunities
Subcommittee on Oversight and Investigations

June 14, 1995

The recent ACGME ruling which mandates that all Obstetrics and Gynecology training programs provide abortion training for residents has nothing to do with education. It represents a brazen attempt by politically isolated leaders in organized medicine, in cooperation with the National Abortion Federation, to coerce individuals and institutions that are morally opposed to abortion into becoming intimately associated with abortion providers. This ruling also promotes the false premise that all physicians within our society support abortion on demand as national policy when in fact there is both moral and medical division within the medical profession of the validity of such a practice.

The Supreme Court decision of Roe vs Wade has, perhaps inadvertantly, created an environment in America where two stark human realities are competing against each other resulting in radically different health care agendas for complex medical/social problems. Indeed, it is the pitting of the needs of the mother against those of her unborn child that accounts for the continued divisiveness of the practice of abortion within our country at large, but perhaps more importantly within the practice of the specialty of obstetrics and gynecology.

Although this fundamental conflict is painfully obvious, the proposed ACGME mandate completely ignores it, claiming instead that it is a lack of education and training that is responsible for a "perceived need" for abortion providers. Nothing could be further from the truth. Mandated abortion training will not teach a single OBGYN resident anything new. The surgical techniques that are utilized in the treatment of stillbirths and miscarriages are identical to the ones performed in elective abortions. The major difference is that abortion involves performing these procedures on a patient whose baby is still healthy and very much alive. What mandated abortion training will succeed in doing, however, is to open the flood gates for proabortion propaganda campaigns to descend upon every

residency training program in America. And although the mandate was for OBGYN programs alone, Family Practice programs have been targeted and similarly inundated as well (see enclosure).

Mandated abortion training is not needed in order for those who support unrestricted abortion access to have opportunities to provide this type of training for those who desire it. Eighty nine percent of current training programs offer optional experience with first trimester abortion training and 82% offer the same optional experience for second trimester procedures. "Moonlighting" opportunities currently exist for those residents who want to supplement their income by providing abortion services and electives and fellowships can easily be developed to provide experiences for those residents and fellows who desire further training as well.

The nonrepresentative nature that characterizes the leadership in organized medicine, (especially that in Obstetrics and Gynecology) coupled with the longstanding practice of actively discriminating against those with differing philosophies is legendary and acknowledged in both the academic and community based clinical practices of our specialty. Although the members of the ACGME asserted they "consulted" with Program Directors in this initiative as a member of APGO (Association of Professors of Gynecology and Obstetrics) who was present at the July 1992 retreat when the representatives of Region 4 voted overwhelmingly to reject this proposal and to leave guidelines for abortion training as they currently existed intact, I can assure you that Program Directors meetings are not exercises of representative democracy...but that of academic dictatorships. In fact, the recognition of this political reality is what led to the inclusion of the mandated abortion question in the nationwide survey in the first place.

When the 37,000 OBGYNs in the country were asked, 59% voted against mandated abortion training. The ACOG (American College of Obstetrics and Gynecology) has gone on record as endorsing that abortion be a part of national health insurance...although 55% of the OBGYN community is against tax dollars being used for this purpose. States, whose citizens chose to pass prolife legislation, have been economically boycotted by the ACOG Board...although 61% of Obstetricians and Gynecologists stated that the ACOG should maintain either a neutral or prolife position on the abortion issue. A former president of ACOG resigned in protest over the Boards hostile antiprolife policies. And physicians who have academic aspirations frequently state that to join a prolife organization is the "kiss of death" for an academic career.

Comments, voluntarily offered by participants in the nationwide survey, are revealing as well. A number of physicians who identified themselves as prochoice thanked the AAPLOG (American Association of Prolife Obstetrics and Gynecologists) for doing the survey as the leaders of organized medicine, to their knowledge, had never polled the people they claim to represent on this important matter. And one physician stated he would be happy to join our organization... once he passed his boards. Apparently he knew that if it was discovered that he was prolife there was a good chance he would be failed.

It is also my understanding that the Medical Ethics Committee of the ACOG recommended that this proposal not be adopted, as it clearly violates the moral conscience of institutions. Furthermore, this policy violates ACOG s own policy statement on abortion which begins by stating:

> "The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected."

How can ACOG claim truly to believe in its own policy when an institution, which has a moral opposition to abortion, must make arrangements with and provide malpractice insurance for every resident who desires training in an abortion clinic? From a prolife perspective, this is like sending a preborn infant to a concentration camp but then proclaiming you are innocent because you were just following orders and did not do the procedure yourself.

Although the leaders in academic Obstetrics and Gynecology are reticent to listen to or consult with the clinicans in this country who practice their trade they readily receive and act on input given to them by representatives and supporters of the abortion industry. In a 1992 article, published in Obstetrics and Gynecology, Dr. David Grimes, in consultation with the National Abortion Federation, argues that abortion needs to be mainstreamed into all residency training programs and "incentives" devised to encourage doctors to do something that many of us find "distasteful". He ends the article with a quote from another similarly minded physician who declared "the medical profession must be **educated** to the fact that abortion is no longer a favor to bestow but, rather, an obligation to perform". It is no coincidence that within 3 years the ACGME decided, in the name of education, to make the provision of abortion training mandatory for all training programs.

Finally I would be remiss if I did not mention that there are negative medical consequences that are frequently suffered by women who submit themselves for abortion procedures. Physicians who categorically state that abortion is fundamental to "comprehensive care for women", reproductive health and economic freedom are apparently unaware of the statistical association between breast cancer and abortion. Since this topic is not covered in the OBGYN "scientific" literature this may explain their ignorance. And clearly there would be no need for

organizations such as WEBA (Women Exploited by Abortion) if postabortion syndrome were not a reality.

In summary, the ACGME mandate has nothing to do with education. Every single obstetrican and gynecologist in this country knows how to do an abortion. The problem for abortion advocates is that most physicians refuse to use their skills in this form of "service"..and that this is true even for many physicians who support the decriminalization of abortion.

This mandate has the clear purpose of "mainstreaming" abortion practice within the medical community and presenting to the American public the totally false impression that all physicians believe that abortion is just another medical procedure when clearly it is not. In fact, Dr. John Fishburne, the Chairman of the RRC, commented in the February 1st edition of OBGYN News that initially all institutions were required to provide the training on site and since only hospitals that meet RRC residency requirements receive ACGME accreditation, the requirements "carry a lot of weight...Residents graduating from nonaccredited programs often have trouble getting hospital privileges and board certification, he added." These statements, by the RRC Chairman, document a profound lack of appreciation for what abortion is and what it means to many members of American society as well as the coercive intent of the ACGME mandate.

If the ACGME is truly interested in providing educational opportunities for residents who desire abortion training they should attempt to mobilize the 47% of the OBGYN community that stated in the nationwide survey that they support abortion as a measure of fertility control and confine their "educational activities" to institutions that share their moral values. They should not be allowed to

use the power of accreditation, as Dr. David Grimes suggests, as an "incentive to encourage doctors to do something that many of us find distasteful".

Prolife physicians and institutions recognize from the daily aspects of our practices that abortion is not only fatal to preborn children but is also harmful to women and serves as a destructive force against the American family. We **refuse** to use our surgical skills to perform a procedure that we can clearly see damages our patients and hurts our nation. We therefore implore that the power of accreditation not be used to promote abortion politics in America. The ACGME should restrict itself to promoting goals that are truly educational in nature.

The following is a letter sent to the president of A.C.O.G. apprising him and the executive board of the A.C.O.G. of the A.A.P.L.O.G. survey.

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October 31, 1994

William C. Andrews, M.D.
President, A.C.O.G.
880 Kempsville Road, Suite 2200
Norfolk, Virginia 23502

Dear Doctor Andrews:

The A.C.O.G. may have some interest in our recent polling of 37,000 obstetricians and gynecologists on the abortion issue. The statistical results are enclosed.

The questionnaires that were completed and returned totaled more than 9,000, almost a 25% return rate, probably unprecedented for a questionnaire on this issue.

Having had the opportunity during the past several weeks to review the thousands of comments on the returns, I am also enclosing a compendium of some of the most salient and meaningful comments along with some of the most frequently repeated ones from both sides of the issue.

Because of the concerns expressed by many respondents that the results be tabulated accurately, the P.P.S. Medical Marketing Group in Fairfield, New Jersey, was responsible for the mail out and the tabulations.

A.C.O.G. representatives are more than welcome to have access to the completed questionnaires and comments. All of them will be kept available for perusal and reference. We will be happy to converse with any of the A.C.O.G. officers and directors about the results of the poll and to confer with them as to their general reactions to it.

Sincerely,

Matthew J. Bulfin, M.D.
Secretary, A.A.P.L.O.G.

MJB:leg
Encl.

(305) 771-9242 • 4701 NORTH FEDERAL HIGHWAY, SUITE B4 • FORT LAUDERDALE, FLORIDA 33308-4663

Editorial Office:
American Association of Pro Life Obstetricians & Gynecologists
4701 North Federal Highway, Suite B4
Fort Lauderdale, Florida 33308-4663

Telephone: (305) 771-9242

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THE FEMALE PATIENT®

COMMENTARY

Changing Attitudes of American Ob/Gyns on Legal Abortion

Denis Cavanagh, MD, Daniel J. Martin, MD, David V. Foley, MD, Matthew J. Bulfin, MD, Watson A. Bowes, Jr, MD, Joseph L. De Cook, MD

On January 22, 1973, the US Supreme Court handed down two decisions—*Roe v Wade* and *Doe v Bolton*—that struck down abortion laws in all 50 states.[1,2] It has since been stated that "abortion remains the most divisive social issue of our time," and we certainly agree with this.[3] However, we fail to understand why the executive board of the American College of Obstetricians and Gynecologists (ACOG) continues to support legalized abortion as "a woman's choice" when it may not even be in the best interest of maternal health. The 1992 report of the American Medical Association's Council on Scientific Affairs notes that although the risk of maternal mortality from legal abortion before 16 weeks' gestation is lower than that for childbirth, the maternal death rate from abortion rises above the childbirth level after this gestational age.[4] Given this fact alone, it is no wonder that legal abortion has become a divisive issue.

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) is a recognized special-interest group within ACOG, and we are increasingly concerned about the parent organization's official stance on the abortion issue. In answer to questions regarding its abortion policy, one of our members received a cordial reply from ACOG on March 2, 1994, stating twice that "80 plus percent of our Fellows [sup]ve of abortion on demand." We seriously chal[illegible]e this statement, because the entire ACOG fellowship has never been adequately polled.

NATIONAL SURVEY

In an attempt to obtain a valid, nationwide survey of attitudes on abortion, the executive committee of AAPLOG decided to poll as many ob/gyns as possible—including all ACOG fellows and junior fellows. A comprehensive list of approximately 37,000 ob/gyns was obtained from *Ob/Gyn News*, and the survey was sent out to all those listed because some physicians who practice obstetrics and gynecology do not belong to ACOG. The questionnaire was printed and mailed by the PPS Medical Marketing Group of New Jersey, which also compiled the results. The questions were constructed to be unbiased and attempted to elicit clear answers from the respondents (Table).

A response from 9165 of approximately 37,000 physicians (almost 25%) was judged to be an adequate sampling. Indeed, this is a relatively high response rate for a survey sent to a large group of physicians with no financial incentive to respond, and may be an indication of the deep concern of the respondents. In addition to answering the nine questions, more than 400 physicians wrote additional comments; this group was divided almost evenly between those supporting and those opposing abortion on demand. As may be expected, some of these comments were quite vitriolic—again emphasizing the strong feelings and deep-seated division among ob/gyns on this issue.

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Table. ACOG Fellowship Attitudes on Abortion

		Yes	%	No	%	No. of responses
1.	Do you believe abortion is justified to save the life of the mother?	8317	93.73	556	6.27	8873
2.	Do you believe abortion is justified in cases of rape and incest?	7066	80.18	1747	19.82	8813
3.	Do you believe abortion is a justifiable treatment option in the case of uniformly fatal fetal anomaly?	8093	90.44	855	9.56	8948
4.	Do you believe abortion is a justifiable treatment option in the case of nonfatal fetal anomalies?	5502	63.31	3188	36.69	8690
5.	Do you believe abortion should be available as a form of birth control for unplanned pregnancies?	4176	47.56	4604	52.44	8780
6.	Do you believe abortion should be paid for with tax dollars?	3930	44.52	4897	55.48	8827
7.	Should abortion clinics be held to the same medical standards as other outpatient surgical facilities?	7066	80.18	1747	19.82	8813
8.	What stance do you feel is appropriate for ACOG to take on the abortion question?					
	Neutral	3848	45.58			
	Abortion advocate	3272	38.75			
	Antiabortion advocate	1323	15.67			
	Total	8443				
9.	Do you agree that every obrgyn residency training program be mandated to include elective abortion training?	3620	40.80	5253	59.20	8873

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ABORTION

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RESULTS

The responses to questions 1 to 3 were not surprising, with overwhelming support for abortion in cases of danger to the mother's life, rape, incest, and uniformly fatal fetal anomalies. We did not expect the high percentage of "yes" responses to question 4, given that many anomalies are relatively insignificant and correctable. Question 5 shows that a majority of respondents oppose abortion for family planning, and question 6 reveals solid opposition to paying for abortion with tax money. Question 7 indicates that 80% of respondents believe that abortion clinics should be held to the same medical standards as other outpatient facilities. Question 8 shows a 61% majority favoring a neutral or antiabortion stance for ACOG. Finally, question 9 elicited a 59% opposition to the residency review committee proposal for mandating abortion training for obgyn residents.

CONCLUSION

In our opinion, this survey suggests that most obgyns do not support ACOG's current position on abortion, with approximately 15% favoring an antiabortion stance, 46% favoring a neutral stance, and only 39% advocating abortion on demand. Contrary to the ACOG's official pro-choice stance, our results indicate that 61% of obgyns favor a neutral or antiabortion position. Also, 59% oppose mandatory abortion training for residents in obstetrics and gynecology. TFP

REFERENCES

1. Roe v Wade 410 U.S. 113 (1973).

2. Doe v Bolton 410 U.S. 179 (1973).

3. Grimes DA: Clinicians who provide abortions: the thinning ranks. Obstet Gynecol. 1992;80:719-723.

4. American Medical Association Council on Scientific Affairs, Council Report: Induced termination of pregnancy before and after Roe v Wade—trends in the mortality and morbidity of women. JAMA. 1992;268:3231.

Denis Cavanagh, MD, is Professor of Obstetrics and Gynecology and Director of Gynecologic Oncology at the University of South Florida in Tampa. **Daniel J. Martin, MD**, is a Reproductive Endocrinologist at St John's Hospital, St Louis, Missouri. **David V. Foley, MD**, is Clinical Professor of Obstetrics and Gynecology at the Medical College of Wisconsin in Wauwatosa. **Matthew J. Bolfin, MD**, is an Attending Obstetrician/Gynecologist at Holy Cross Hospital, Fort Lauderdale, Florida. **Watson A. Bowes, Jr, MD**, is a Professor in the Department of Obstetrics and Gynecology at the University of North Carolina at Chapel Hill. **Joseph L. De Cook, MD**, is an Obstetrician/Gynecologist in private practice in Holland, Michigan.

BEHIND THE NUMBERS

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papers. This group clearly identifies itself as a recognized advocacy group, and deserves a hearing before the readership. However, I would vastly prefer an unbiased presentation of meaningful statistics that allow for individual interpretation. Physicians did not acquire their degrees by shirking their academic duties.

The majority of Americans surveyed have gone on record as pro-choice. Does this mean that they are absolutely convinced that abortion is right, or are many Americans who are neutral or even personally opposed to abortion convinced that it is still an individual decision with no business as part of the public forum? Is the majority always right? In some instances, the majority has been wrong and was shaped by the politics of the day. In a democratic society, though, the majority rules. This is not to say that minority positions should not be heard. However, to make real progress in reducing abortions, counseling on abstinence, contraception, and the role of the family must take priority.

If abortion is such a major issue for the ACOG Fellowship, then I think it merits more than a 10-question mailing. Such oversimplification only leads to more contention in an area that is already littered with bombshells. Indeed, I am offended by a group (such as ACGME) that would thrust the question of abortion on Catholic hospitals which, by their very nature, cannot remain neutral. Students who apply for residency at these hospitals know that abortion training will not be provided. I am tired of the tendency on both extremes to proclaim their own superior morality and their authority to decree what is right for America and the world. I doubt that there will ever be a meaningful dialogue on abortion, and I fear that if either side "wins," the net result will be to further reduce the right of practitioners and patients to follow their own moral and ethical beliefs.

In closing, please do not write to me with your opinions on this commentary. For once, I neither care nor wish to hear. The voting booth has a curtain to maintain privacy, and I will continue to draw that curtain. TFP

Thomas E. Nolan, MD, is Associate Professor of Obstetrics and Gynecology and Head of the Section of General Obstetrics and Gynecology at the Louisiana State University School of Medicine in New Orleans and Associate Editor-In-Chief of THE FEMALE PATIENT.

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL

The School of Medicine
Department of Obstetrics & Gynecology
Division of Maternal-Fetal Medicine
(919) 966-4631
FAX (919) 966-6171

The University of North Carolina at Chapel Hill
CB# 7570, 314 MacNider Building
Chapel Hill, N.C. 27599-7570

February 9, 1995

John I. Fishburne, M.D., Chairman
Department of Obstetrics & Gynecology
University of Oklahoma College of Medicine
P.O. Box 26901
Oklahoma City, OK 73190

Re: ACGME
Special Requirement that all Ob/Gyn residency training programs provide an opportunity for residents, who so choose, to participate in the performance of induced abortions

Dear John:

I appreciate your discussing this matter with me yesterday. With all due respect, I believe that such a requirement is unnecessary and has the potential of alienating a substantial number of practitioners in our specialty. Although, the requirement will be a hardship for only a small proportion of the residency training programs, namely those in Catholic hospitals, the perceived intention and insensitivity of such a requirement will do far more harm than good.

I submit the following observations in support of my contention that the special requirement mandating all residency programs to make available a rotation for the performance of induced-abortion is unnecessary. Let me add that I am not Roman Catholic, I practice in a hospital in which induced abortions are performed, and I am a faculty member in a department that offers training in induced-abortion to its residents.

The techniques that must be learned to perform induced abortions are the following:

1. Dilatation of the cervix with metal dilators, often preceded by the use of various cervical inserts (laminaria, etc.)
2. Exploration of the uterine cavity with a sound and the extraction of tissue from the uterus with a variety of forceps.

3. Curettage of the endometrial cavity with suction and with dull and sharp curettes
4. The induction of uterine contractions with high-dose oxytocin or transvaginal prostaglandins.
5. Amniocentesis in a second trimester pregnancy to either remove amniotic fluid or inject substances into the amniotic fluid.
6. Transabdominal and transvaginal sonography to determine fetal age, fetal position, number of fetuses, position of placenta, and assess the completeness of a uterine evacuation procedure.

All of these procedures or treatments are variously utilized to treat patients with spontaneous incomplete or missed abortions, second trimester fetal deaths, and to perform fetal diagnostic procedures. In other words, an Ob/Gyn service need not perform induced abortions to teach these procedures and treatments, nor must a resident perform induced abortions to learn them.

With our without the Special Requirement about induced abortion training, a resident is and will be allowed to complete a residency program without having performed induced abortions. However, the resident should have learned the procedures and treatments enumerated above while caring for women with spontaneous abortions, fetal deaths, and in performing tests of fetal evaluation.

Fourth-year medical students who are candidates for Ob/Gyn residency and who are seeking experience in performing induced abortions, should apply only to those residency programs that offer such experience, either within the program or as an extramural elective. All residency programs should clearly state in their application brochures and promotional literature whether experience with induced abortion is offered.

Of the 274 residency programs in the United States that are listed in The APGO/CIBA Directory of Residencies in Obstetrics and Gynecology, 1994, only eight (3 %) require residents to perform 1st trimester elective abortions, and four (1.5%) require residents to perform 2nd trimester abortions.(1) Eighty-nine percent of the programs offer opportunities for residents to perform 1st trimester elective abortions, and 82 percent offer opportunities for residents to perform 2nd trimester abortions. In other words, it does not seem to be the expressed opinion of the current directors of residency programs and chairmen of departments of Obstetrics and Gynecology that residents must be required to perform abortions to successfully complete their residency education. Furthermore, most residency programs currently offer training in first and second trimester elective abortion.

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A 1994 poll of obstetrician/gynecologists in the United States demonstrated that the majority of the respondents do not favor requiring residency training programs to include elective abortion training.(2)

Finally, the Committee on Ethics of the American College of Obstetricians and Gynecologists recommended the following at its meeting on April 12, 1994:

> "The Committee on Ethics of the American College of Obstetricians and Gynecologists has consistently recognized the importance of respect for the moral integrity of individual physicians. It is important to respect the moral integrity of institutions as well. The proposed Residency Review Committee requirement that all residency training programs provide the opportunity for training in elective abortion fails in this regard. This requirement would violate the moral integrity of some religious institutions that maintain residency programs. It should not be adopted. Other approaches should be explored for improving the training of physicians in abortion techniques."

The effort to require all Ob/Gyn residency programs to include training in induced abortion as a requirement for accreditation seems to arise from a perceived need to increase the number of abortion providers in the United States.(3-6) As noted above, the problem, if there is one, is not related to a lack of programs that offer training in elective abortion. Many, if not most, Ob/Gyn specialists who are pro-choice do not perform more than a few, if any, induced abortions. I dare say, the reason for this is not their inability to perform abortion-related procedures, but rather that, for most obstetricians, performing induced abortions is an unpleasant, emotionally draining task that runs counter to their usual work of enhancing and supporting fetal life.

I hope these comments may be of some value in the upcoming discussions about this matter.

Thank you.

Sincerely,

Watty

Watson A. Bowes Jr., M.D.
Professor

References:

1. Ling FW, Holzman GB, Mitchum MJ. APGO/CIBA Directory of Residencies in Obstetrics and Gynecology, 1994.

JAN-07-1995 11:01 P.04

Association of Professors of Gynecology and Obstetrics, 409 12th St. SW, Washington, DC 20024.

2. American Association of Pro Life Obstetricians and Gynecologists (AAPLOG). In 1994 AAPLOG sponsored a survey to determine the position of American Obstetrician/Gynecologists regarding induced abortion. Through an independent survey organization a questionnaire was sent to 36,000 Ob/Gyn's in the United States to which there was a 25% response. Among the questions asked was "Do you agree that every ob-gyn residency training program be mandated to include elective abortion training?". To this question 3620 (40.80%) responded, "Yes", and 5253 (59.20%) responded, "No". Results of the entire survey have been submitted for publication.

3. Grimes DA. Clinicians who provide abortions: The thinning ranks. Obstet Gynecol 1992;80:719-723.

4. Westhoff C, Marks F, Rosenfield A. Residency training in contraception, sterilization, and abortion. Obstet Gynecol 1993;81:311-314.

5. Rosenfield A. The difficult issue of second-trimester abortion. N Engl J Med 1994;331:324-325.

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Fullerton, CA

AAPLOG American Association of Pro Life Obstetricians and Gynecologists
850 Elm Grove Road, Elm Grove, Wisconsin 53122 Phone: (414) 780-7984
Fax: (414) 782-8788

August 12, 1992

MEMO TO: AAPLOG Officers and Directors

FROM: David V. Foley, M.D., President

Recently, I submitted the following resolution to the Annual Meeting of the Wisconsin Section of the ACOG. The resolution was approved by a small majority, and is now being submitted to the Annual Meeting of the 6th District of ACOG. Hopefully, it will be approved there, and then forwarded to the Board of Directors of the ACOG.

I would encourage each of you to submit a similar resolution to your state sections, or directly to your district. The more sections and districts we can get to support our position, the more impact this will have on the leadership of the ACOG.

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RESOLUTION RE: ACOG Stance on Rights of the Unborn

WHEREAS, there is a divergence of opinion among the membership of the American College of Obstetricians and Gynecologists as to what constitutes "rights of the unborn", and

WHEREAS, recent actions and pronouncements on this subject by the ACOG have polarized the membership, and

WHEREAS, the AMA has recently adopted a neutral position on this question, now therefore be it

RESOLVED that the Wisconsin Section of the ACOG support a resolution to the 6th District of the ACOG asking the ACOG Board of Directors to also adopt a neutral stance on the politicized question of abortion.

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AMWA
801 No. Fairfax St.
Suite 400
Alexandria, Va 22314

April 1, 1995

Dear Family Practice Residency Program Director

As you know, the Accreditation Council of Graduate Medical Education has unanimously adopted a policy[2] that requires all accredited OB/GYN residency programs to offer training to their residents in the performance of induced abortion and the management of abortion related complications beginning in January of 1996. With this unanimous vote, the medical establishment has taken a committed step toward establishing its professional autonomy and integrity regarding medical education and voluntary reproductive health care. A copy of the new policy is enclosed.

For family practice physicians, the new training policy presents an opportunity to facilitate their training curriculum to increase the number of comprehensively trained physicians and ease the abortion controversy.

Many individuals including residents-in-training continue to have concern for harassment and violence against clinicians who perform abortions. Fear, unfortunately, reinforces the marginalization of abortion from mainstream medicine. Faced with these realities, every responsible measure should be taken to ensure the safety of physicians and their patients. The authors and editor of the enclosed issue of the Journal of the American Medical Women's Association offer some challenging solutions.

[2]The requirements permit residents to "opt out" of abortion training. Every program must provide training either in-house or off-site to residents who do not object. All residents must be trained in the complications of abortion. (see attached ACGME policy statement)

The journal examines the opportunities for integration of abortion into the medical mainstream through health care financing, medical technology, mid-level clinicians, the replication of innovative physician training programs, and legislation. The authors and editor of the journal are collaborating to identify resources to resolve some of the issues of medical training, professional responsibility and ethics.

We anticipate that you and your institution may have logistical problems as to how to implement the new ACGME policy. We hope that the enclosed JAMWA issue and the appended list of resources can assist your service and institution in the implementation of any required changes.

Sincerely,

Seymour Romney, M.D.
Chairperson
Society of Physicians

Allan Rosenfield, M.D.
Steering Committee Member
Society of Physicians

Diana Dell, M.D.
President
AMWA

Enc. JAMWA Vol. 49, Number 5, Sept./Oct. 1994
"Medicine and Abortion."
list of annotated organizations and resources
ACGME requirements

The Medical Center
Beaver, Pa., Inc.

James P. McKenna, M.D.
Director, Family Practice Residency Program
918 Third Avenue
Beaver Falls, PA 15010

April 4, 1995

Dear Jim,

As you may be aware, the Accreditation Council of Graduate Medical Education (ACGME) of the American Medical Association has recently unanimously adopted a policy that requires all accredited OB/GYN residency programs to offer training to their residents in the performance of induced abortions beginning in January of 1996. Rapidly on the heels of this announcement, I received a letter from The Society of Physicians for Reproductive Choice and Health which states that, "For Family Practice physicians, the new training policy presents an opportunity to facilitate their training curriculum to increase the number of comprehensively trained physicians and ease the abortion controversy." With the letter they mailed a copy of the Fall 1994 issue of the Journal of the American Medical Women's Association (JAMWA) dealing with the topic of abortion and medicine.

This issue of JAMWA supposedly offers "challenging solutions" to the anticipated problems our program may have in excitedly and voluntarily instituting these new training policies into our program (even though the new policy applies only to OB/GYN training programs). A major suggestion of JAMWA was to train physicians from other specialties as well as mid-level clinicians to perform abortion services. I believe this suggestion is a first step in an effort to apply the ACGME policy to Family Practice training programs. This policy states that,

> If a residency program has a religious, moral, or legal restriction which prohibits the residents from performing abortions within the institution, the program must insure that the residents receive a satisfactory education and experience managing the complications of abortion. Furthermore, such residency programs must have mechanisms which insure that residents in their program who do not have a religious or moral objection receive education and experience in performing abortion at another institution.

Please notice that the restrictions mentioned are "programatic", not "institutional".

I realize that our residents have varying attitudes concerning the religious or moral appropriateness of induced abortion, and that some may request training

1000 Dutch Ridge Road
Beaver, PA 15009
412/728-7000

in abortion procedures. In anticipation of such a request, and with the authority of the Director of OB/GYN Training, I want to pronounce and establish our training program as one which has absolute moral restrictions which prohibit training our residents in induced abortion. Any position other than this which allows The Family Practice Residency Program of The Medical Center of Beaver to participate in electively terminating viable pregnancies will be grounds for my immediate resignation.

Please file this letter for future reference in the event of questions arising concerning this policy.

Sincerely.

Kevin C. Dumpe

Kevin C. Dumpe, M.D.
Director of OB/GYN Training
The Family Practice Residency Program
The Medical Center of Beaver, PA
1000 Dutch Ridge Road
Beaver, PA 15009

Seymour Romney, M.D.
Chairperson, Society of Physicians for Reproductive Choice and Health
In concert with AMWA and Planned Parenthood
801 N. Fairfax St.
Suite 400
Fairfax, VA 22314

April 4, 1995

Dear Drs. Romney, Dell, and Rosenfield,

As the Director of OB/GYN Training of The Family Practice Residency Program of The Medical Center of Beaver, PA, I recently received your packet of materials concerning the recent decision of the ACGME to require abortion training in all accredited OB/GYN training programs.

I would like to contend with some of your statements and implications. You proudly state that with this decision, "the medical establishment has taken a committed step toward establishing its professional autonomy and integrity regarding medical education and voluntary reproductive health care." The medical establishment has historically enjoyed a large measure of professional autonomy. I believe you are here referring to a new declaration of moral autonomy. Do you not question the appropriateness of any human institution being morally governed without accountability to any independent standard? The sole standard then becomes this institutions own definition of moral uprightness. This is a prescription for rapid corruption, but is exactly the circumstance you proudly trumpet with this statement. This policy is a significant step backward into the immoral muck.

You then assume the appropriateness of extending an invitation to Family Practice training programs based on a policy meant only for OB/GYN programs. We have no desire to be included under such a dark umbrella, largely due to our broader patient care focus including concern, not only for women inconvenienced by an unplanned pregnancy, but also fathers, siblings, extended families, and preborn children.

I have yet to be stymied by logistical problems of which you warn in providing abortion services, as the impregnable moral wall prevents me from even seeing such an obstacle. You are fighting on a downhill battlefield as the AMA, ACOG, and apparently AMWA join you in support of abortion rights. I am but a small obstacle to your goals - but I am not in the minority.

I have notified our program director that we are officially a training program with "moral restrictions" that do not allow abortion training and will not participate in terminating viable pregnancies.

Sincerely,

Kevin C. Dumpe, M.D.
OB/GYN
Member - American Association of Pro-Life Obstetricians and Gynecologists
Director of OB/GYN Training
The Family Practice Residency Program
The Medical Center of Beaver, PA
1000 Dutch Ridge Road
Beaver, PA 15009

Proposed Abortion Training Stirs Controversy

By Tracy Panzica
Staff Writer

When a New Hampshire hairdresser, who allegedly killing two employees of Massachusetts family planning clinics and shooting at a Virginia clinic, ob-gyn educators were working on ways to increase the number of residents trained in providing abortions.

"I think ob-gyns as part of their training need to know how to evacuate a uterus, and I'm concerned when graduates of programs in America don't have that knowledge," said Dr. John Fishburne, chairman of the ob-gyn Residency Review Committee of the Accreditation Council for Graduate Medical Education.

The RRC is in the final stages of submitting new proposed ob-gyn residency training requirements for approval by ACGME. Those draft requirements obligate ob-gyn residency programs to provide first-trimester abortion training to all residents who do not have religious or moral objections to doing abortions.

Religiously based or other institutions that have moral, ethical or legal objections to providing abortion training must arrange for the training to be provided elsewhere for their residents who are not objectors, the requirements state. Although residents who have objections to learning to perform abortions will not have to do them, all residents still will be required to learn

> *"The Catholic hospitals weren't happy, and I received lots and lots of letters, which finally sorted out to 50/50."*

to manage abortion-related complications.

The requirement that institutions with objections to abortion make sure training is provided to ob-gyn residents has stirred up a lot of controversy, according to Dr. Fishburne.

"The Catholic hospitals weren't happy, and I received lots and lots of letters, which finally sorted out to 50/50 for and against the requirement," Dr. Fishburne said. "Most of the mail didn't come from [residency] program directors, it came from Catholic bishops and their constituencies or from Planned Parenthood."

The requirement has actually been watered down somewhat, he continued. "Where we first wrote it, all institutions were required to give the training themselves unless the residents had objections, but in response [to the controversy], we add the escape clause for the institutions."

Since only hospitals meeting RRC residency requirements receive ACGME accreditation, the requirements carry a lot of weight, Dr. Fishburne said.

Residents graduating from unaccredited programs often have trouble getting hospital privileges and board certification, he added.

The Board of Directors of the American College of Obstetricians and Gynecologists "supports the recommendations in general," although it has not voted on them, said Dr. Stanley Zinberg, director of practice activities at ACOG in Washington.

Dr. Zinberg expressed concern about

(Continued on page 71)

ACOG Takes Steps to Further Menopause Education

By Kathy Schmidt
Staff Writer

More women receive the bulk of their information about menopause from the news media than from their own physicians, according to a North American Menopause Society survey.

Findings like this have spurred the American College of Obstetricians and Gynecologists to launch a program that it hopes will better educate women and

group sessions that assessed what women in their forties and fifties understood about menopause.

"We were pretty amazed by the fact that so many women were ill-informed or misinformed" about menopause, said ACOG President William C. Andrews, professor of obstetrics and gynecology at Eastern Virginia Medical School, Norfolk.

"Of all women only one knew about the risks of heart disease after menopause," he said.

their information about menopause and women's health issues from the media. Only 36% responded that their physician was the main source of such information.

Slightly more than half of the surveyed women reported that they received gynecologic care from an ob-gyn. The rest of the women said that they received such care from a general practitioner, family physician or internist.

The discussion now page is created by

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PRACTICE ISSUES

Proposed Abortion Training Requirements Stir Ethical Controversy

(Continued from page 2)

the continuing availability of abortion services. "How can you not have some pessimism when you recognize all the pressures being brought on ob-gyns not to do abortion?" he asked.

"If you're the only person that performs abortions in a small town, and your children are followed and harassed, and signs are put up on telephone poles saying 'Murderer' with your picture on them, it's very difficult to deal with," Dr. Zitzberg said.

The proposed requirements were written 2 years ago and have been looked at by the RRC, ACOG, the American Board of Obstetrics and Gynecology, the residency directors, and the American Medical Association. They are scheduled for review by ACOME on Feb. 13 and 14. If approved, they would go into effect in either January or July of 1988, Dr. Fitzpatrick said.

> *"How can you not have some pessimism when you recognize all the pressures . . . not to do abortions?"*

"I'm comfortable with the proposed requirements the way they are now," he said. "I hope they won't have to be significantly changed."

Statistics on the percentage of residents currently receiving abortion training are difficult to come by. A newspaper article quoted a figure of 32%, but several sources said they weren't sure where that number came from.

A 1985 survey of 200 residency programs showed that 23% of institutions included first-trimester abortion training as a routine part of residency, and 50% offered it as optional training.

The 28% of programs that did not offer abortion training represented a near 3-fourfold increase from 1978, according to the survey, which was published 2 years later in Family Planning Perspectives (19:158-62, 1987).

"If anything, the situation is worse today than it was then," Dr. Zitzberg told OB/GYN. News.

SIMPLY ONCE-A-DAY DOSING

Low incidence of GI side effects (<1%)

- Most common treatment-related adverse effect is symptomatic *Candida albicans* vaginitis (1.1% of 1,020 patients)

Once-a-day dosing

- 5 g of cream (containing approximately 100 mg clindamycin phosphate) administered intravaginally at bedtime for 7 consecutive days

Diagnosis of BV–

A clinical diagnosis of BV is usually defined by the following:

Homogeneous vaginal discharge that:

- has a pH >4.5
- emits a "fishy" amine odor when mixed with 10% KOH solution
- reveals clue cells upon microscopy

Gram's stain results will show:

- *Lactobacillus* morphology absent or

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Graduate Education

CLINICIANS WHO PROVIDE ABORTIONS: THE THINNING RANKS

David A. Grimes, MD

access to abortion services in the United States has become increasingly limited because of a decrease in rural hospital providers and a growing shortage of clinicians willing to offer this service. As of 1988, 83% of United States counties had no identified provider. The deficit in numbers of clinicians stems from the current imbalance between incentives and disincentives. The single most powerful incentive appears to be altruism. On the other hand, disincentives include poor pay, frequent harassment, low prestige, suboptimal working conditions, and tedium. In 1990 a symposium on abortion provision was held, sponsored by the National Abortion Federation and ACOG. Among the remedies suggested by the attendees were increasing the integration of abortion training into the mainstream of residency education, improving the pay and work environments of clinicians, and where feasible expanding the capacity of physician providers by using midlevel practitioners working under physician supervision. (Obstet Gynecol 1992;80:728–729)

> We cannot fail to recognize that the performance of legal, elective abortion is indeed essential to preserving women's health, therefore making it an unavoidable responsibility of physicians and hospitals in rendering health care. Unless they do take on this responsibility enthusiastically and thoroughly, the unhappy and dangerous impact on the young women of our nation will be incalculable.
>
> E. W. O. Stewart, 1971[1]

The legalization of abortion was a necessary but insufficient step toward the provision of abortion services for women in the United States. As suggested by Overstreet[2] 2 decades ago, these services ultimately depend on the availability of affordable clinicians who are both skilled and willing to provide abortions. To the extent that such clinicians are not available, the public health promise of legal abortion will go unfulfilled.

In recent years, access to abortion services has become increasingly limited, because of both the dearth of facilities in rural America[3] and the growing shortage of clinicians providing the service[4] (also O'Hara D. Abortion. MDs who do them and those who won't. American Medical News, December 9, 1989; Kolata G. Under pressure and stigma, more doctors shun abortion. New York Times, January 8, 1990; Gomez C. Abortion in the heartland. The Washington Post, October 2, 1990). In 83% of United States counties, in which 31% of women of reproductive age live, there is no identified provider.[5] Some states, such as South Dakota, have but a single physician who performs abortions. Thus, many South Dakota residents seeking abortions must travel long distances, which both increases expense and compromises care should complications develop. Access is a challenge in other rural states. In Wyoming, more than half of women who obtained abortions in 1985 traveled to another state for care.[5]

Distance clearly matters in women's reproductive choices; in one rural state, abortion rates were found to be inversely related to the distance to a provider.[6] Because of the significant public health implications of the growing shortage of clinician providers, this article will review some incentives and disincentives influencing professionals' involvement in this field and discuss potential solutions to the problem.

Influx and Retention of Clinicians

Two factors govern the rate of recruitment and retention of clinicians providing abortion services: training and incentives. Both appear to be inadequate. The last published nationwide survey of resident physician training in abortion[7] was conducted in 1985. Although the majority of residency programs in obstetrics and gynecology offered training, the proportion had declined 22% from the proportion in a survey conducted

From the Department of Obstetrics and Gynecology, University of Southern California School of Medicine, Los Angeles, California.

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a decade earlier. A survey conducted in 1991 revealed that the proportion of programs in which first- and second-trimester abortion was routinely (as opposed to optionally) taught had declined since 1985 (MacKay HT, personal communication, June 2, 1992).

Most abortions today take place in freestanding abortion clinics, not in teaching hospitals.[2] Hence, even in those hospitals where abortion training is provided, the limited numbers of cases may compromise residents' ability to develop sufficient surgical expertise. For example, only 10% of residency programs reported that their residents collectively performed over ten abortions per week.[3] Others[2,4] have echoed this concern about numbers of hospital abortions, noting that 45% of hospital providers in the United States perform fewer than 30 procedures per year. Whereas ten abortions per week may provide an adequate case load for surgical training, 30 per year is unlikely to be adequate even for programs with few residents.

In programs that offer abortion training, the level of resident participation is directly linked to the programs' expectations.[3] Where training is expected as a matter of course, the majority of residents participate. Where programs make training an option, fewer elect to be involved.

Other thoughtful commentators in the early years of legal abortion made this observation:

> A serious problem that impedes [resident] physicians' enthusiasm for abortion is lack of technical challenge and variety for those who perform the procedure. They feel that abortions are boring and repetitive, are not a necessary learning experience, add to their already heavy work load, and use time they would rather spend taking care of a variety of more interesting and challenging patients.[5]

When already overworked, few residents will opt for additional elective work. Moreover, few academic departments have faculty with both a deep commitment and a busy practice of abortion to serve as role models and mentors for residents. Hence, this "minor" surgery is relegated to low priority among the many activities competing for residents' time.

Organizations concerned with the content of residency training have an inconsistent approach to abortion. In its "Design for Resident Education in Obstetrics and Gynecology,"[6] the Council on Resident Education in Obstetrics and Gynecology states, "In order to provide adequate training in surgical skills, a program must have a faculty proficient in the required skills and must provide sufficient opportunity for individual instruction in each procedure to all residents" (emphasis mine). Although D&C and laparoscopy are specified, the document does not mention abortion.

The Council's "Educational Objectives for Residents in Obstetrics and Gynecology"[7] is more explicit. For example, one terminal objective is:

> Given an 18-year-old woman, 9 weeks pregnant, who requests termination of pregnancy, the resident should be able either to arrange contact with a facility and personnel with skills and attitudes that permit them to respond to her request or to provide education, counseling, support in decision making, and, where indicated, carry out the surgical procedure.

The same approach is taken with a patient requesting a second-trimester abortion.[7]

The American Board of Obstetrics and Gynecology, Inc. certifies physicians as having special competence in obstetrics and gynecology. Its written and oral tests include abortion topics, and the Board requires candidates for the oral examination to report their experience with abortion. Nevertheless, the Bulletin[8] of the Board does not specify a requirement for expertise in abortion:

> Residents should have acquired the capability to perform, independently, major gynecologic operations, spontaneous and operative obstetric deliveries, to manage the complications thereof and be capable of performing the essential diagnostic procedures required of a consultant in obstetrics and gynecology.

"Minor" operations, such as abortion, are not mentioned.

Given adequate training in abortion and a large demand for those skills, what motivates a clinician to provide the service? Three factors appear important: altruism, esteem, and compensation.[9] The desire to help women in need seems to dominate. To the extent that beneficence prevails, physicians will be willing to provide abortions. Two other motivations, gratitude and high pay, no longer exist in the provision of abortion; these problems are discussed later.

Effect of Clinicians

Out-migration of clinicians providing abortions appears to be exceeding in-migration for two reasons: natural attrition through retirement and premature discontinuation due to dissatisfaction. The latter problem has been termed the "graying of the abortion provider."[10] Leaders in the field who were instrumental in the repeal of restrictive laws are now approaching retirement age. Many of these were motivated by having cared for patients who had been injured or killed by illegal abortions. Clinicians younger than

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...ese early 40s today may have never encountered such ...nts, and hence may lack the personal commit... ...of older providers to ensure that these conditions ...not recur. For example, a recent survey of family ...hysicians in Kansas[39] revealed that physicians older ...an 40 years were more likely to support abortion ...ghts than were their younger colleagues; this pattern ...as observed for both sexes.

Harassment and intimidation may dissuade skilled ...hysicians from entering this field or convince them to ...uit. Harassment of providers takes many forms, rang... ...ng from picketing of homes and offices to obscene ...elephone calls to death threats. On an organizational ...asis, this may translate into loss of hospital privileges ...nd close scrutiny by state licensing boards because of ...the supposed "shadowy" nature of abortion practice.[4] Abortion clinics have been the targets of an epidemic ...of arsons and bombings; during 1984, 1% of all clinics ...in the United States were attacked.[11]

Performing abortions no longer pays well. Because ...the cost of abortion (and the corresponding physician's ...fee) have not kept pace with inflation, both are now ...well below market value. In 1972, a first-trimester ...abortion in a clinic in New York city cost approximately ...$147; in 1989 dollars, that would translate into about ...$568 (Henshaw SK, personal communication, October ...25, 1990). However, the average cost of such abortions ...in 1991 was below $300.[12] Thus, the true cost of an ...abortion is about half that in the early 1970s."[13]

During this interval, physicians have been paid progressively less for providing the same service. In 1973, physicians customarily received about $50 per case, the equivalent of about $190 today (Henshaw SK, personal communication, October 25, 1990). In contrast, current fees usually range from $30–50, with the largest private clinic provider in the nation paying $25 per operation. Invited to work part-time in an abortion clinic, one young gynecologist replied, "I can generate as much income seeing office patients with vaginitis as I can by doing abortions . . . and without the hassles."

Poor compensation for abortion services is a problem in other countries as well.[14]

Working conditions for clinicians providing abortions are frequently unsatisfying. For clinicians who have spent years honing their diagnostic skills, abortion largely underutilizes their abilities and relegates them to the role of a technician. As noted by Potts, "When the patient was a 'client' who had decided on the prescription, this eliminated half the medical mystique and demoted the doctor to technician or tradesman."[15] Both the evolution of new clinic personnel (abortion counselors and nurse-practitioners) and the rapid flow of patients in clinics have depersonalized the abortion experience, not for the patient but for the clinician. For some, communication may be limited to a brief discussion with the patient on the operating table before surgery.

Management protocols in clinics may regiment the practice of medicine. For example, some physicians work part-time in clinics as independent contractors. As such, they may have little input into protocols for patient management, thus depriving them of their traditional autonomy in clinical decisions. Instead of serving as the captain of the medical team, the physician may be only the "hired help" for the day. Because of a perceived lack of medical control, some physicians have been reluctant to work in abortion clinics.[4]

Isolation can occur. Clinicians whose practice is limited to abortion services may become estranged from the medical community. "In private practice the attending is still judgmental, equating abortion with illicit sex or hostility toward motherhood. His colleague who fulfills his obligation to society under the new law is little better than yesterday's abortionist in his eyes."[16]

The tedium of largely repetitive operations can be compounded by the emotional stress surrounding unwanted pregnancies and families in crisis.[16,17] A practice limited to women with personal crises differs markedly from the usual mix of patients in an obstetric and gynecologic practice. On the other hand, some physicians find helping women to resolve personal crises especially rewarding.

Potential Solutions

In response to the growing problem of insufficient numbers of clinicians providing abortion, a symposium sponsored by the National Abortion Federation and ACOG was held in 1990 to explore the problem and to recommend solutions.[5] The recommendations covered three general areas: improving the training of resident physicians, removing disincentives to abortion provision, and exploring the use of physician-supervised midlevel clinicians to perform abortions.

First, abortion must be integrated into the mainstream of residency training. How this is done will necessarily depend on local settings. High-quality abortion training can be offered within university residency programs, as occurs at the University of North Carolina School of Medicine[3] and the University of California San Francisco School of Medicine.[18] In these centers, highly visible and well-respected faculty teach residents both first- and second-trimester abortion. In some residencies, discussions about abortion are included in seminars on medical ethics, which helps to integrate abortion into the curriculum and to clarify residents' personal feelings about the issue.

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Where insufficient patient volume or high costs of hospital-based care deter such services, extramural training in freestanding clinics can be arranged, as occurs at the University of Vermont School of Medicine.[5] Professional liability insurance coverage for residents training in extramural facilities can pose problems. Precedents exist, however, for having training in extramural sites covered under an umbrella policy for residents. Alternatively, abortion clinics may carry insurance that will cover physicians working in the facility.

Of course, exemptions from training should be allowed for those opposed to abortion on religious or ethical grounds. However, some residents decline not because they are opposed to abortion but because this will lighten their work load if no alternative duties are assigned. Others may opt out not because they have a moral aversion to abortion but because they feel no moral obligation to perform the procedure. Some residency programs may pressure residents to participate in this "elective" activity by requiring them to arrange for their own coverage if they choose not to perform abortions. In some cases, this translates into extra nights of duty.

[illegible]nd, current disincentives to involvement must be replaced by incentives. Communities must curb the harassment of clinicians. Actions of local law enforcement officials can make a difference. Vigorous prosecution and conviction of perpetrators helped to counter the epidemic of anti-abortion violence across the United States.[6] Having one's telephone lines jammed, door locks glued shut, and family threatened (Gornes C. *The Washington Post*, October 2, 1990) should not be part of the price of practicing medicine. Working conditions for clinicians need upgrading. In addition, clinicians need to be granted more authority and autonomy in freestanding clinics.

Paying clinicians appropriately for their services will likely overcome much of the current reluctance. Few surgeons are willing to receive one-fourth today what they did 20 years ago for performing the same operation. Inequitable compensation for this service denigrates its value to the patient and to society.

Third, the use of physicians other than obstetricians-gynecologists and non-physician providers should be pursued. For example, suction curettage is well within the scope of practice of family physicians.[7] Although the notion of a paramedic provider of abortion is not new,[8,9,20] nontraditional providers have recently established an enviable record of accomplishment. Some states, eg, Montana and Vermont, allow midlevel clinicians under the supervision of physicians to perform abortions.[5] In Montana, a physician assistant has been providing this service for over 12 years. In Vermont, physician assistants have been documented to have first-trimester abortion complication rates comparable to those of physicians (relative risk, 0.9; 95% confidence interval 0.6–1.4; $P = .61$).[21] The requisite skills clearly can be acquired by physician assistants, nurse-practitioners, and nurse-midwives, if they desire to learn.

Abortion remains the most divisive social issue of our time. Despite strong professional support for legal abortion (American College of Obstetricians and Gynecologists. Abortion attitudes. Little change in 14 years. ACOG News Release. August 28, 1985), there remains a "lack of enthusiasm and even opposition from many gynecologists, who consider abortion a distasteful chore."[22] Regrettably, many aspects of medicine are both distasteful and a chore; these personal considerations, however, must never influence one's decision about doing what is best for the patient. As noted 20 years ago, "... the medical profession must be educated to the fact that abortion is no longer a favor to bestow but, rather, an obligation to perform."[10] If we as a nation and as a professoin default on this obligation, the legacy of *Roe v. Wade* will become an empty promise in the years to come.

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Chairman HOEKSTRA. Thank you, Dr. Smith.

I believe all the Members have a copy of the proposed changes. I just have a little question on this. Explain to me why I would not interpret this as a political agenda when you have added in that for schools that take a moral or religious objection they have to make sure that they do not impede—this is explicitly written in the new guideline—that they may not impede residents in their program who do not have a religious or moral objection from receiving education.

Then, number two, that they must publicize such a policy to all applicants to that residency. Where is the language on the other side that goes to schools that are required to teach this that says, "You will not coerce any student to actually participate in this training, and you must publicize that in all your literature that that is part of your curriculum?" Where is the fairness in this that you specifically have now put that language in here for people who have religious and moral objections? They have to publicize it and make sure that they do not impede, but on the other side, it is kind of like, hey, you do not have to tell.

What makes me believe this is not a political agenda?

Dr. D'ALESSANDRI. Thank you very much for the question, and I can answer that in several ways. First of all, the ACGME has responsibilities to students, residents, and to the public, and students who are applying to programs need to know the parameters of those programs. If those programs have lost accreditation, students who are applying for those programs need to know that.

This is an important issue for students to know, and the ACGME council feels strongly that this is one of many important issues that students need to know.

The second response to your question is that we have tried to balance this issue of what is appropriate in training for those people who will be performing this procedure after their training in their regular practice in order to make sure that they are competently trained and serve the public well.

This is a legal procedure, and if they are going to be performing this procedure later on, they should be competently trained.

The third issue there is that——

Chairman HOEKSTRA. Excuse me. Those that go to other schools are not competent to provide this training, and you have statistics to show that?

Dr. D'ALESSANDRI. I did not say that the schools are not competent to provide the training. I said that the——

Chairman HOEKSTRA. Students coming out of these schools will not be competent.

Dr. D'ALESSANDRI. The residents who come out of the training programs that are going to perform this procedure need to be trained to do this procedure competently, and that is one of the important responsibilities the ACGME has to the public.

And, thirdly, I think this does take into account those institutions that have religious, moral, or legal restrictions, and allows them not to participate and not to actively participate, and all they need to do is not impede those residents who plan to do this procedure later on from getting training on their own.

Chairman HOEKSTRA. This is balanced?

Dr. D'ALESSANDRI. I think this is a very balanced approach.

Chairman HOEKSTRA. I think it is fair to say that where ACGME has come out on balance is much different than where any other part of this country today has come out on balance in describing and discussing this issue.

Is it also then safe to assume that based on the testimony that you have given that the students and the doctors that over the last number of years that have graduated from the 88 percent of medical residency training institutions that do not require abortion training as part of their requirements, that they are really not competent and that the medical training that they have received really—we have heard testimony that the training that they receive is not much different and they can handle these situations—you are basically saying that the majority of the doctors out there today are basically incompetent in dealing with this issue.

Dr. D'ALESSANDRI. What I am saying to you is that the majority of medical opinion in this country, the American College of Obstetrics and Gynecology, the residency review committee, the program directors of obstetrics and gynecology in this country, feel that it is important for this procedure to be trained, to be a part of training programs during residency in obstetrics and gynecology for those residents who do not have moral, religious, or legal restrictions from providing this service.

Chairman HOEKSTRA. This really does concern me. Obviously these people are not qualified, and we have many doctors out there. Is there some way that we can go back and catch these people that have graduated in the last five or 10 years and as part of their certification for medical training, that they now go back and get this additional training to make sure that they are qualified to do that? Is that the next step in this process?

Dr. D'ALESSANDRI. No.

Chairman HOEKSTRA. That for all of these OB–GYNs out there today practicing, that over the next five years we require them to be trained?

Dr. D'ALESSANDRI. No.

Chairman HOEKSTRA. Why is that not a natural step?

Dr. D'ALESSANDRI. I did not say that. What I said was that it is the opinion of medical specialists in this area that training for this procedure is important.

Chairman HOEKSTRA. Right, and they do not have that training. So why wouldn't this be a natural follow-up that says to protect the public we should have a remedial training program that makes sure that doctors that have graduated from our medical schools now get this training?

Dr. D'ALESSANDRI. Because if you have a religious or moral objection——

Chairman HOEKSTRA. No, but I mean——

Dr. D'ALESSANDRI. [continuing] to this, then why should you——

Chairman HOEKSTRA. Eighty-eight percent of the medical schools have not been training in this practice or it has been an elective.

Dr. D'ALESSANDRI. I do not know what you are talking about. I have not seen that data. So I cannot respond to that data.

Dr. LING. Mr. Chairman, may I respond?

Chairman HOEKSTRA. Yes.

Dr. LING. The issue of competence on an individual level is totally separate from the issue of requiring the education of that procedure. What we are talking about here, what you are raising is are those individuals who have previously trained when there was no such requirement, are they competent? That is not something that can be determined as a blanket statement. That has to be determined on a case-by-case basis.

What is important here is that the concern that we all have is for the quality of care for the patients, and this is a procedure which requires training, like any other operation. If you will, it is like a hysterectomy. I do not believe that Congress would feel comfortable in trying to teach residents how to perform or when to perform or how to manage complications of a hysterectomy.

Abortion is a technique that has many subtleties to it and, therefore, must be taught with a degree of sensitivity and mechanical expertise also. So I think what you are asking is actually a different issue than what the ACGME is proposing here.

Dr. LEVATINO. Congressman.

Chairman HOEKSTRA. Yes.

Dr. LEVATINO. If I may add to this discussion, I think the issue of training and somehow the induced abortion, there's something magic about it in terms of being very different from the training that every resident gets until it comes out of their ears taking care of miscarriages—almost one in four pregnancies end in miscarriage. That is a lot of patients that you have to do D&Cs on for miscarriage, spontaneous miscarriage.

Fetal death in utero even in the second trimester is not all that rare. We see this and deal with this on a regular basis in our training program.

I really have to take issue with this idea that somehow a resident must be trained with induced abortion on live kids to be able to do this procedure competently. As one example, when I graduated from my residency in 1980, the laser was brand new to gynecology. I got no training in laser when I was a resident because there was no such training available.

When this came to the fore in practice, I knew that this was an important part of my practice. I went, took a course, learned how to use a laser with proper instructors, and then went and did my procedures. It is not that difficult to learn. This idea that somehow if residents are not forced to do it during their training years as residents I find objectionable and misleading.

Chairman HOEKSTRA. Dr. Smith, do you really believe that there is broad-based support at the professional level for these changes?

Dr. SMITH. No, I do not, and I think that it is important for people to realize that what happens is there is a political reality about these program directors meetings that they keep referring to, that if you kind of understand the corporate culture that exists in academic medicine, these are not meetings where the board, so to speak, says, "Well, Program Directors, tell us what you want. Let's all vote on it, and then we will decide what is best for residency training."

Basically what happens at these meetings, and I have been to a number of them since 1990 when I first started as Medical Director at the program I am associated with, the program directors are in-

formed of what they will be doing, period, and there is lots of discussion, and there is lots of give-and-take, but I think most of the program directors who go there recognize that what is basically going on is you are being told what they have decided you are going to do.

At my own organization, I know the American Organization of Pro-Life OB–GYNs has been writing different leaders in organized OB–GYN since 1973 when Roe v. Wade became a reality. We have continuously asked that they poll the clinicians that provide these services so that they can give us accurate feedback as to whether or not physicians who are in the field support a lot of their decision which are patently pro-abortion, and I know of at least two communications to former Presidents of AAPLOG in which the Board stated, number one, 80 percent of all OB–GYNs support what we are doing, though they never had any data to back that up, and number two, in 1983, I believe, one of the last letters that Dr. Bulfin sent them, he basically wrote them back and said they were not going to poll the membership because it would cost $5,000 and they knew what the answer was anyway.

When we polled the entire Nation and spent $40,000 doing it, the results that we obtained at least from the people that practice OB-GYN in this country, almost across the board, did not support virtually any decision that came out of organized medicine in the name of OB–GYN.

So I do not question that they are concerned and they have their own opinion about what is best, quote, to educate doctors in the country. I would question, number one, whether they are representative. I would question, number two, whether they even listen to people that have any kind of a notion that the prenatal human being is a person, and we, therefore, have a very big moral problem with the way they are approaching this issue.

I think that it is also very obvious that if you look and you ask the people in our profession, that we are just as divided as everybody else is in the lay community, and so I do not think that any attempt to demonstrate that this is something that has been agreed upon in academia is—it has been agreed upon by the people who sit on the board, but it has not been agreed upon by the people who actually practice the specialty in this country.

Chairman HOEKSTRA. I will yield to Mr. Sawyer, but I cannot help but express my disappointment for where ACGME is on this. In listening to the testimony and having studied this issue, I really believe this is one where leadership of the medical organizations has run amuck, that is, a pushing of a political agenda, and I can only ask a couple of questions.

You know, why are you doing this to Congress? We have entrusted you with a significant responsibility, and you have moved it into a political agenda, and you are going to find that as you move—you have to recognize the decision you have made. You have made a political decision and, as such, you can expect political bodies to become involved in that process, which is what nobody on this panel has wanted to do and was why we entrusted the medical profession with those responsibilities in the first place.

You have moved out of the box to where you are today. It is not Congress moving into your box. You have moved out of your sphere

into ours, and that is why we are having this hearing. That is why we are going to be proposing legislation, and that is why we are dealing with this issue, because of the political decisions that you have made.

I will now yield to Mr. Sawyer.

Dr. D'ALESSANDRI. May I respond to that?

Chairman HOEKSTRA. I am yielding to Mr. Sawyer.

Mr. SAWYER. Mr. Chairman, I would be pleased to have Dr. D'Alessandri respond to the comment if you would be comfortable with that.

Chairman HOEKSTRA. Yes, fine. It is your time.

Mr. SAWYER. I know. I just want to observe that we did not keep time on your turn.

Chairman HOEKSTRA. It must have been an oversight. We did not keep time on my time? I am sorry about that.

Mr. SAWYER. We did not.

Chairman HOEKSTRA. We will be very generous with the gavel as we traditionally are in this committee.

Mr. SAWYER. I thank you, sir.

Chairman HOEKSTRA. Thank you.

Mr. SAWYER. Doctor?

Dr. D'ALESSANDRI. My comment is, first, that this is not a political decision on the part of the ACGME. This process came up as part of the normal review for these guidelines over two years ago.

In addition to that, the standard that had been set many years ago was the requirement for family planning. Within that standard, training and abortion was part of that standard. It had always been part of that standard, and the only thing that the new standard does is make that more explicit and put it into language that is much more clearly understood, but that has been the standard forever or at least for the last 10 years for this RRC.

Mr. SAWYER. Thank you.

Let me just observe that politics is not limited to publicly elected political bodies. Politics exists within corporate structures, within universities, within labor unions, any place people come together. The decisionmaking process particularly around divisive issues inevitably involves the give and take of human tensions, which is, in part, one of the characteristics of the work that we do here.

I clearly sense that there is a political division within the profession, and I think that we do well to acknowledge that here. I take on face value that the traditional role of the medical profession as it comes before us today has sought to acknowledge that political difference perhaps not to the satisfaction of those represented across this panel, this panel representing a broad spectrum of differing views within the profession.

But I have to return to the issue that I raised, Mr. Chairman, when we began this hearing, and that is the long and well accepted tradition that the Congress not engage itself in the establishment of specific accreditation standards for educational programs. We have always deferred to experts from the chosen field or profession, and the Federal Government has never, to my knowledge, involved itself in the determination of the appropriate level of education required to practice in a particular medical specialty.

Let me just turn to the two folks who have been engaged in this directly, this process, Dr. Ling and Dr. D'Alessandri, about why it is most appropriate for medical experts to make these kinds of decisions and whether you both would agree that it would be a dangerous precedent to transgress that longstanding tradition.

Dr. Ling.

Dr. LING. As I mentioned before, I believe it would, indeed, be most appropriate to turn to those with the greatest expertise in the area with the greatest access to the scientific knowledge that we have to determine the standards by which we are educating the practitioners of the future, and I believe that ACOG has stood by those principles in its goal of trying to represent the practitioners.

I would like to take a moment just to clarify because I know this committee is meeting for informational purposes. I think it is important that you have all the information. Dr. Smith referred to a survey which is purported to represent more accurately the feelings of obstetricians and gynecologists when in reality it does not. It received only about 25 percent response of the 37,000 or so questionnaires that she sent out.

Interesting enough, of those 25 percent respondents, only 16 percent actually considered themselves anti-abortion advocates. So I think that when you start looking at surveys particularly with regard to very emotional issues, the science of those surveys, how well representative they are of the people who are surveyed has to really be kept at a very modest level.

But I think that what the committee ought to try to focus on is how best to take care of women, to provide the best health care for these patients as we try to do in our practices. We recognize that individual physicians will choose not to perform abortions, but at least they have the training by which should they be required to do so on an emergent basis they will have had the optimal opportunity to do so.

Mr. SAWYER. Dr. D'Alessandri.

Dr. D'ALESSANDRI. Professionals who provide services and teach must be allowed to oversee the curriculum for the professionals in their programs. It would be a disaster for Congress or a legislature to become involved in defining what is the appropriate curriculum for a physician, whether in obstetrics-gynecology or internal medicine or any area.

Could you imagine what kind of program we would have if we would allow that? It would be almost as bad as the ACGME passing laws for the country. That is not something that ACGME does or is interested in. It is not a political organization in the sense of doing anything more than looking at quality in programs and accrediting those programs to protect the public.

I think it is really essential that the education for our professionals, for the lawyers or physicians or whatever, remain in the hands of those people who understand it best, and, yes, there is difference of opinion within the profession, and, yes, there should be. But this issue that I think I am hearing today extends beyond the profession and is something totally different.

As long as this is a legal procedure, we should be training people so that they can perform it competently.

Mr. SAWYER. We have heard several times both from Dr. Smith and Dr. Levatino that the surgical techniques and the treatment of stillbirths and miscarriages are identical to elective abortions. Could you comment on that and whether or not those techniques are sufficient for induced abortion?

Dr. D'ALESSANDRI. Dr. Polen is here with me. He is the Vice Chair of the RRC and an obstetrician-gynecologist. I think he could answer that very well if you would allow that.

Mr. SAWYER. Mr. Chairman, we would have no objection.

Chairman HOEKSTRA. I believe we have some experts on the panel who are——

Dr. LING. I could answer that, Mr. Congressman.

I think what we are dealing with here are a wide range of patients. The issue of just the mechanical techniques is only part of the overall picture. The needs of a patient who has undergone a spontaneous miscarriage is one very sensitive issue, but the needs of a patient who is facing the dilemma of carrying a pregnancy, whether conceived under unusual circumstances, is totally something different, and in order for our physicians to have the maximum ability to deal with both the emotional, psychological, as well as the technical issues, being exposed to the whole gamut of this wide myriad of patients is very important in order to insure that a patient is being taken care of by the most competent of practitioners.

Mr. SAWYER. Let me ask one closing question. I would agree that it is genuinely a sad reality that over a million and a half abortions are performed in the United States every year. Is there any other procedure performed this frequently for which a physician does not need to be trained?

Dr. LING. Very simply, no. There is no other procedure that falls in that category. Clearly, to give patients the best care, the physicians and the practitioners must receive the best training possible to render the best care.

Dr. D'ALESSANDRI. I know of no other procedure.

Mr. SAWYER. Thank you.

Thank you, Mr. Chairman.

Chairman HOEKSTRA. Mr. Weldon.

Dr. WELDON. Thank you, Mr. Chairman.

My questions I would direct first to Dr. D'Alessandri and Dr. Ling.

As a physician myself who is pro-life, I have had the opportunity to discuss this issue with a number of my colleagues over the years, and while I find that very many of them take a pro-choice position on this issue, they usually always say to me that they would never perform the procedure, and they would never consider performing it, and when you ask them why, it is because they are very well aware of the fact that it is the taking of a human life, and they like me went into the field of medicine because they wanted to help people and care for people and heal people, and that this particular procedure runs directly in contradiction with those moral principles that led them to go into the medical profession.

Now, in essence what you are going to be doing with your new accrediting requirements is pushing more residents into learning

this procedure, and that is, in effect, something that they do not want to learn and that they do not want to perform.

At least when I was in, as an internist I did not go through an OB–GYN residency, but when I was a medical student rotating on the OB–GYN service, there were some residents who did not want to have anything to do with this procedure. There were some faculty members that did not want to have anything to do with the procedure, and the system seemed to work out very nicely in that they could just stay away from it, and the ones who wanted to learn it and the ones who were willing to do it could teach the ones who wanted to know it, but in effect, you are placing a further mandate on this procedure. At least that is what it appears to me from reading your regulations that you are trying to promulgate.

Dr. D'ALESSANDRI. No.

Dr. WELDON. And then I would additionally like to say that you have put us in an awkward position because we have delegated authority to you to regulate the profession or at least we have indirectly delegated it by not getting involved, and when you pass a regulation like this, it will put us in an awkward position in the sense that to get Medicare funds for reimbursement for residents, they have to be in an accredited program, but we passed the Religious Liberties Act, which says that you cannot force people into this, and there is a lot of indirect coercion that goes on in training programs.

At least when I was a medical student and I was on call one night and the resident told me he was going to do an abortion, I was in the awkward position of either saying, "Yeah, I will come along and watch," or annoying this guy and in effect perhaps jeopardizing my ability to get a reasonable grade out of the course.

So if you could comment on some of these things, I have some very, very serious concerns about what you are doing, and I have to say I agree with the Chairman on this issue that this seems to me to be a very politically motivated agenda.

Dr. D'ALESSANDRI. Mr. Weldon, let me comment that during your training and your experience and your ability to say, "No, I do not want to perform that," what we have done with this guideline is to maintain the exact same conditions for residents. If the resident says that they feel that they have a moral or religious objection to doing this procedure, they will not have to do that procedure. That has not changed whatsoever.

And, in fact, what we have tried to do is to make sure that there are good protections for residents. One of the responsibilities the ACGME has is not only to the student, but also to the resident, and so, therefore, we will insure that residents who have moral or religious objections to performing this procedure will not have to do that.

Dr. LING. As an extension of that, the training of these residents who choose to utilize these skills must be as good as it can possibly be in order to maximize the quality of health for these women. Yet we all recognize the fact that some physicians even who are trained, who during residency choose to obtain this training, may choose not to utilize those skills or may be forced to utilize those skills in an emergency situation, but again, we would all certainly

want the physician to be able to apply at his or her own choosing those techniques.

Dr. WELDON. Well, let me just go back to the original regulation that you proposed. Now, I realize you are attempting to change that, but the language that you originally proposed stated that such residency programs must have mechanisms which insure, insure, that residents in their program who do not have religious or moral objections receive education and experience in performing abortion; you are saying performing abortion, not dealing with complications.

Dr. D'ALESSANDRI. That language has been changed, Mr. Weldon, and I have provided a copy of the revised language, and as I testified earlier, this was done subsequent to meetings with the Catholic Health Association, with Dr. Fishburn who is the chair of the RSC, Mr. Allen, who is the chair of the ACGME, and myself and a number of others, and understanding their position a little bit better than perhaps we had, so the language has been changed so that it is that they do not impede residents in their program. They do not have to take an active role in providing this.

Dr. WELDON. Well, just to go back to what the Chairman said earlier in your new proposed regulations where you have, number one, they shall not impede and, number two, must publicize such policy to all applicants to that residence; I think it would be a reasonable thing to also require that they must publicize that they will require residents to receive this training to allow those applicants to the residency program who object to this procedure to be aware of what they are getting into in the training program.

I am running out of time. I would just like to direct——

Chairman HOEKSTRA. We are running a generous gavel.

Dr. WELDON. We are?

Chairman HOEKSTRA. Yes.

Dr. WELDON. Okay.

Chairman HOEKSTRA. I hope you are not offended, Mr. Roemer.

Mr. ROEMER. We will take that under consideration, your recommendation, sir.

Dr. WELDON. Dr. Levatino, you said that you were performing abortions and you now no longer do. If you could, if you do not mind, if you would please explain why you abandoned that procedure.

Dr. LEVATINO. Explain why?

Dr. WELDON. You abandoned performing abortions as part of your practice.

Dr. LEVATINO. To tell that story completely would take more time than I think is reasonable, but I had no religious or moral compunctions about doing abortions as a resident, and as I said, I was one of only three practitioners that I am aware of in the capital district around Albany, New York, that performed D&E or second trimester abortions up through 20 weeks. I was very popular in terms of getting referrals for that procedure because so few physicians do them.

When I was engaged in my training as a resident, I was learning to do abortions and doing a fair number, as I said, had no compunction about them whatsoever, but at the same time happened

to have a situation where my wife and I were desperately trying to adopt a child because we could not have one of our own.

We were also very fortunate in being able to adopt. I have mixed feelings about abortion only because of my own selfish reasons at that time, because of the inability to find a child and knowing darn well that I was part of the problem, one of the reasons why I could not find a child to adopt.

Once we adopted our child and had our family, those concerns evaporated because, as I said, my selfish goal was achieved, and as I said, in private practice I continued to do abortions for five years, again with no compunctions about them.

Two things really drove me out. One was I got a belly full of seeing bodies ripped apart in D&E abortions with literally those little dead faces looking up at me from the table. It is absolutely abhorrent, and what really hit me across the head was that the little girl that we were finally fortunate enough to adopt was killed in an auto accident, and she literally died in my wife's and my arms, and having gone to that and then trying to get back to business as usual, I could not. I could not possibly tolerate it, and I stopped.

Dr. WELDON. Well, I appreciate you sharing that. Obviously that is a very sensitive issue.

Dr. Elkins, did you have a comment that you wanted to make?

Dr. ELKINS. Yes. I think one of the things that we might say that might be helpful to this discussion is that we keep talking of abortions as if they are all one entity. Mid-trimester abortions, especially D&E, is a very complicated procedure, and I am wondering if, you know, as they are thinking of revisions even further, which I hope they will do, I wonder if the ACGME would not consider separating out the concept of mid-trimester abortion training, which I think all of us have had to do that procedure which occasionally it is in every way medically indicated.

That is a procedure that does require some training. What we are talking about here is the first trimester procedures, which we are being all pushed now to participate, which makes it appear to all of us to be overtly a political statement on the part of the ACGME, not a medical one, which is what we keep coming back to.

If they separate out in their thinking the mid-trimester procedure, which is a difficult one, from the rest of terminations of pregnancy, it will make more sense to OB–GYN programs, to all of us, because it is a distinctly different, complicated, and complex procedure that does require somebody to teach you how to do it besides what some of our residencies do provide. There is a big difference.

What we have here today from the ACGME, and what all of us have read in their papers and literature that they have sent to us appears to be a political agenda. That is what is so bothersome to us, and none of us want politics involved here, from the committee or from the government. I think maybe it might help if they considered this a little separately in their further deliberation.

Dr. WELDON. Thank you, Mr. Chairman.

Chairman HOEKSTRA. Mr. Roemer.

Mr. ROEMER. Thank you, Mr. Chairman.

As this panel is learning quickly, and as the audience probably already knows, Members of Congress, although we say that we are

not going to get involved in issues, we pontificate and promulgate on everything from sewers to space, from flag burning to flag waving, and I am sure that we will give you our opinions on this issue and other issues today and tomorrow, and there is a great deal of concern about this standard.

I personally think that this standard is unclear. It needs clarification, and I think that it has tipped the balance, so to speak. I have a number of questions about the old language and the new language and what you are attempting to clarify.

Specifically, Dr. D'Alessandri, let me ask you a couple of questions. You have expanded the language now to include in the first sentence in the new language "experience with an induced abortion must be part of residency training, except for" and the new language here is "programs and" and then the old language, "residents with moral or religious objections."

So you have included now programs in addition to residents. Out of 268 residency programs, about 31 of those, I believe, are Catholic residency programs, and my question would be very specifically to you: given the conscience clause exclusion on ethical and legal and religious exclusion, how will both individual residents and now programs which you've expanded it to, how will these people and programs be eligible under the conscience clause exclusion? What processes could they go through to gain this now?

Dr. D'ALESSANDRI. Okay. The way this would be evaluated, and this is, I think, what you are asking me, is that during the residency review of the program, the program would identify itself as a program having a religious or moral objection. Therefore, those questions related to the performance of abortion during the residency would not be relevant.

The residents would be asked if they have a religious or moral objection, as well, and those would be noted.

Now, within the residency program, the last part of this also makes it the requirement that the program notify applicants of their religious or moral objection to the performance of this procedure. So residents coming into the program would understand that and would know about that.

Mr. ROEMER. So, again, I think I need more clarification. So if you are one of the 31 Catholic hospitals that is now eligible as a program to be excluded under the conscience clause, they still have to go through all of these other steps, although they are recognized as a program, to not impede residents, to publicize policy to all applicants in the residency, and do all of that, even though they are eligible as a program to be excluded under the conscience clause?

Dr. D'ALESSANDRI. They need to inform applicants, yes.

Mr. ROEMER. They still need to go through all of these things?

Dr. D'ALESSANDRI. They need to inform applicants. I am not sure what you mean by all of these things.

Mr. ROEMER. Well, number one and number two.

Dr. D'ALESSANDRI. Yes.

Mr. ROEMER. Has the Catholic Health Association agreed to this new language?

Dr. D'ALESSANDRI. They have looked at the language and, I think, feel that programs at their hospitals can meet this standard.

Mr. ROEMER. But is that a ringing endorsement?

Dr. D'ALESSANDRI. I think from that association that is probably a ringing endorsement.

[Laughter.]

Chairman HOEKSTRA. Mr. Roemer.

Mr. ROEMER. You are not putting the words in their mouth.

Chairman HOEKSTRA. If the gentleman will yield.

Mr. ROEMER. I will be happy to yield.

Chairman HOEKSTRA. I believe that we have information that states that the Catholic Healtn Association does not support this new policy. Their hospitals may meet this requirement, but that does not mean that they support this policy.

Mr. ROEMER. Okay. Well, I thank the Chairman for clarifying that.

Dr. D'ALESSANDRI. I gave you my opinion of what that statement meant.

Mr. ROEMER. You were saying that you thought that the Catholic Health Association did endorse this language.

Dr. D'ALESSANDRI. No, I did not. I said that they can meet this requirement.

Mr. ROEMER. But I asked you did they support this language. You said that they could meet the requirements.

Dr. D'ALESSANDRI. That is correct.

Mr. ROEMER. My question was do they endorse this.

Dr. D'ALESSANDRI. That is correct, and I said I thought that that was a ringing endorsement, but I did not mean to imply that they had endorsed this.

Mr. ROEMER. Another question I would ask to Dr. Ling. Dr. Ling, you used one of the hypothetical examples in your testimony about the need to provide these abortion techniques, and one of the example was that a woman finds out that she has a birth defect and that there is not a doctor within 250 miles that can perform the abortion.

So were you then saying that we need to train residents with abortion techniques so as to immediately come in within, what, a two-hour period or a 10-hour period and perform an abortion based upon the decision of the doctor and the family and the woman? Why does that have to be in such an expeditious time frame? Why would that be a legitimate example?

I certainly understand, although do not agree with, your example of the woman hurt in the car accident, but how then do you make the assumption that this needs to be a technique based upon a medical hypothetical where the time factor might not be as needed as in the first example you used?

Dr. LING. I appreciate that question because it does, indeed, address the subtleties with which we are dealing with a wide range of clinical cases. What I excerpted for you in my testimony were three specific examples in only one physician's experience over the last year in his midwestern practice, where patients that ultimately were needing treatment with techniques of abortion did not have physicians who were prepared to provide those services, in some cases on a more emergent basis, in other cases in a less emergent basis, but nevertheless cases in which the option or the opportunity to even have someone discuss with them in a knowledgeable

fashion the pros and cons so that she could make an informed decision was not even available.

I think that is why the concept of allowing the education of all residents who do not have a moral or legal or other type of restriction on them, allowing the maximum number of people to be exposed to the best education and training possible, will ultimately lead to what we all want, which is the best care of patients in allowing them to control their own destiny as far as knowing what the complications, the benefits of various techniques and therapies are.

Mr. ROEMER. Certainly seen from my viewpoint, and obviously I am not a physician, but you were making a decision based upon there was not a doctor within 250 miles rather than the care of the patient, and again, I think that is one of the reasons why this language needs to be further clarified.

Even the new language, I think, needs to be further clarified in terms of its intent, in terms of the conscience clause and exclusion.

I would just sum up with one final question, Mr. Chairman, and that is in reading through the graduate medical students' choices of residencies, and maybe this question becomes a little bit more moot if there is language put in that further exempts these Catholic hospitals and programs, but I do not think this language does it especially since the Catholic Health Association is not in favor of it, but it seems like students have little choice as to what school they can pick. It is more like a national lottery system.

Are there any efforts to change that system so that we do not see the kind of conflicts that are arising in this debate?

Dr. D'ALESSANDRI. The ACGME is not involved in the residency matching program. It is not part of that.

Mr. ROEMER. I am not specifically asking you to comment on that as a member of your organization. I am asking you a question about what seems to be a very, very random process. Are there suggestions from you in terms of not your position on the council, but from your position as a physician? What do we do to address that randomness and the resulting conflicts that come about?

Dr. D'ALESSANDRI. I do not think it is quite a random selection as it may appear, Mr. Roemer. I believe that students actually do get to choose, and I think that in our institution at West Virginia University School of Medicine, for example, 85 percent of our students receive their first choice, and probably 98 percent or 95 percent at least receive their first or second choice.

So I do not think it is quite as random as it might appear

Mr. SAWYER. Will the gentleman yield for just a moment?

Mr. ROEMER. I would be happy to yield.

Mr. SAWYER. If I could, Mr. Chairman, because I am not sure I am going to be able to return after my vote, particularly when it comes to program and hospitals, we have been operating under, I think, an assumption that a hospital that refused to fully comply with this changed standard would lose its accreditation and thereby be denied Federal funding. Is either of those circumstances the intent of the ACGME?

Dr. D'ALESSANDRI. Not only not the intent, Mr. Sawyer, but to my knowledge no program has ever lost its accreditation because of failure to meet this standard.

Mr. SAWYER. This standard in its currently proposed form or in any of its previous iterations?

Dr. D'ALESSANDRI. In any of its previous iterations, which required training in abortion procedure.

Mr. SAWYER. Thank you very much.

Thank you for your latitude.

Mr. ROEMER. Mr. Chairman, I would just say that I will continue to have deep concerns about even this new language, given that the Catholic Bishops and the Catholic Health Association and a number of the very, very relevant organizations that are directly involved in the negotiations on this very sensitive point do object to this new language, and I think that there will be considerable controversy about the new language even though certain opinions are that it solves some of these problems.

And I thank the Chairman.

Chairman HOEKSTRA. Thank you.

The subcommittee will recess and reconvene at three o'clock.

[Recess.]

Chairman HOEKSTRA. The subcommittee will reconvene. Thank you.

Mr. Souder.

Mr. SOUDER. Thank you, Mr. Chairman. I appreciate the opportunity to be able to ask questions today and would also like to be able to ask some further questions in writing and also allow the witness to answer in a little more detail after the hearing for the record because some of the questions I want to ask I would like to get some factual things on the record that we have left a little bit up in the air.

I first want to state just kind of as an opening comment of what is likely to be the major debate if any legislation is to come up and put myself on the side of the Chairman as far as it may seem to the association that we are entering a political process or that it did not seem like a political process. Personally I question that, and I really think that part of an exchange like this is that we need to treat each other as adults.

You made a political decision. It obviously had not used the word "abortion" in your language before, and you have done that. You have now entered the most contentious modern issue, and you have put us in a situation.

Of course, we have the right as stewards of taxpayer dollars to then intervene. If you would deny certification to African-American doctors or to Asian doctors, we would step in and not allow Federal funds to be used. When you put yourself in the political arena, you are now in the political arena. I wanted to make that statement on the record because that is one of the things we are likely to debate.

But there are a couple of factual questions that I wanted to get into. One is the survey. Dr. Smith, there was some question. Is it accurate that you had about a 25 percent response rate and 9,000 responses? Was your organization identified? Was it an outside firm? Did people know who it was going to, questions like that? Was it geographically balanced?

Dr. SMITH. Yes, I do want to talk about the survey. Number one, the survey was sent to 37,000 OB–GYNs throughout the Nation.

Mr. SOUDER. By your organization?

Dr. SMITH. By my organization, American Association of Pro–Life Obstetrician-Gynecologists.

We identified ourselves. The results were tabulated by a private firm. So we had no control over the answers that we received. We asked, which is something that organized medicine has failed to do, about this particular issue. We at least asked people: give us your answer.

We had 10 questions we asked, which I have provided for the committee, and we identified who we were. We received a 25 percent rate which was 9,000 questionnaires returned out of the 37,000 sent.

To assume that that, therefore, is not representative of what OB–GYNs think in the country, first I would say, look at surveys that are done on this issue. I am sorry I did not bring it with me, because I had actually a pamphlet on scientific or what you call probability surveys. Probability surveys mean that you can draw statistically valid conclusions from the results that you get.

On this particular issue they said generally you need at least a response rate of 1,500. That is the first thing.

The second thing is that when you look at when the abortion issue was asked by people throughout the country, the breakup on answers to questions that we asked was identical to questions that are asked of Americans of every shape and form. So the assumption that because it was only 25 percent is not representative, I would say that our survey represents very accurately the divisive nature of this issue, and because OB–GYNs are people like other people, it is not surprising that our survey results were very comparable to what other scientific results have shown.

Mr. SOUDER. If I could get some additional information on the record, I think your last statement is accurate. It may not be a scientific sample, although doctors, I would assume and from my personal experience, are a little less shy even if they are against a group. Certainly by having it be the group it skews it a little. Nevertheless, 3,600, if you take the 40 percent who disagreed with you, responded, and one of the questions that I had was not this kind of in generic meeting terms, but in the association when you polled, do you have any evidence of 5,400 on one side or 3,600 on the other side of any people asking you to change the policy or against the policy in your files?

In other words, it is one thing to say this 9,000 is not representative. Dr. Ling cited three cases from one doctor, but did you have a groundswell? Do you have lots of letters that were demanding a change? Any evidence that a change was demanded when you have a survey that at the very least shows the divisiveness?

Dr. LING. Again, I think that from the standpoint of ACOG, the issue here is the quality of care of patients and optimizing the quality of care for those women for whom we render the care. It is based upon what we believe to be the best scientific evidence and the best use of the expertise that is available to the specialty, across the specialty.

We certainly recognize the fact that there is divisiveness. You are exactly right, Mr. Souder, because, indeed, the American Association for Pro-Life Obstetrician-Gynecologists is what we call an interest group within ACOG. It is a recognized interest because it is

not something that we want to exclude. In fact, we embrace the diverse nature of our practitioners because there are many varying views.

Mr. SOUDER. Apparently you did not have any demand from the membership of the committee decision that decided as far as your medical standards. In other words, you did not poll or you do not have mail or you do not have people saying, "Oh, we have got people who are practicing abortions who do not know what they are doing." There is no even informal evidence of the need. It was a decision from the top that you needed to include it in the training.

Dr. LING. No, sir, that is not correct. ACOG has historical evidence, both surveys in the 1970s and 1980s. They were not a vote per se. They were random distribution of surveys to ACOG fellows at the time, and fully 85 percent were in favor of the position that ACOG was taking.

Mr. SOUDER. I would be interested in seeing any evidence like that or others of contact and needs that led to this.

Dr. LING. I will make sure that ACOG does forward that information to you.

Mr. SOUDER. Another question——

Dr. D'ALESSANDRI. Mr. Souder, excuse me.

Mr. SOUDER. Yes, sir.

Dr. D'ALESSANDRI. You have to understand there are two different organizations here. The ACGME, through its residency review committee, also as I described the process, asked for comment from many organizations across the country. We received over 300 responses, and many of these are from large organizations, the AMA, the AAMC, other groups, also the College, as well as other groups, and we received about 300 favorable responses.

Mr. SOUDER. On the abortion language in particular?

Dr. D'ALESSANDRI. That is correct, and about 80 negative responses.

Mr. SOUDER. Any information you can provide on the specifics of that would be helpful.

Is it true that the Medical Ethics Committee of ACOG recommended against this?

Dr. D'ALESSANDRI. Dr. Ling should answer that since he is representing ACOG.

Dr. LING. The College position was not against the specific language. I think it is important to understand that the College has not been able to respond to the language or has not even seen the language that has been presented this afternoon. So ACOG has not been able to respond to what we are looking at.

Dr. D'ALESSANDRI. Let me answer that also, sir, if I might because this is a process, as I described before, that went over several years and comment was asked at many different stages and at many different stages of the development of this document.

There was comment which said, you know, we are not happy with the way it is stated at this point and modifications were made.

Mr. SOUDER. Dr. Smith made a very specific point. The Medical Ethics Committee of the American College of Obstetrics and Gynecology recommended that such a policy not be adopted. Is that true?

Dr. LING. I think it is important to understand that ACOG's position was that institutions and individuals should not be coerced, and that is constant with what we are talking about today, allowing individuals and institutions to self-select into their participation in these activities.

Mr. SOUDER. I would appreciate getting a copy of the statement with comments from Dr. Smith and from the association because I realize the language is still formulating even as we participate in this hearing today, but it would be very helpful for us when we hear a very specific thing like that to be able to sort through that difference.

Dr. Ling had several very specific cases that you use as an example and imply that they showed the need for this. I wondered if Dr. Levatino, I think, or Dr. Hannigan could comment on the specifics of those three cases, and then if Dr. Ling would like to make a comment, too, I am curious as to why you think the existing medical training that was there would not have been able to handle these and would that not be true of other things as well.

In other words, somebody may have a medical degree but not be able to handle a specific variation even if they had one short class or whatever. In other words, it may not alleviate the problem.

Dr. HANNIGAN. The cases Dr. Ling brought up concerned mid-trimester abortions which actually would not be covered by this particular change in the policy. This has concerned itself largely with induced abortion in the first trimester.

Also, the conditions, I think, even though they were tragic would fall within the purview of a person adequately trained in maternal-fetal medicine and could be handled, I think, by a maternal-fetal medicine specialist or even a well trained obstetrician.

Dr. LEVATINO. I want to echo that all of these are second trimester situations. We have a dead fetus at 23 weeks at one point, and we have two live fetuses in the other two examples. I dare say there is not a resident in my program either who does or does not do abortions on a regular basis that would not know how to handle these.

Dr. LING. I appreciate Dr. Hannigan's and Dr. Levatino's comments on that, except they have totally misconstrued the purpose of those examples, and I think they are misrepresenting to the committee the purpose and the intent of ACOG's position.

The point is that these were patients who had actual conditions for which at least in those circumstances had a physician who had not had previous training in handling abortion techniques. Those patients' needs could have been addressed more directly and by a more highly qualified clinician.

By no means, as Dr. Hannigan has suggested, is the issue of induced abortion the case here. What we are talking about is just teaching educationally the techniques that some physicians may need in their practice. So I think that, again, what we are trying to provide here is a statement that will allow the best training for these physicians to render the best care to patients in the long run, irrespective of the circumstances in which they find themselves.

Mr. SOUDER. I would like to make sure that the record is clear, and if anybody wants to make further comment in the record on that, which is that in reality you all kind of passed ships in the

night there. In fact, your cases do not prove that anybody who would have had a course in a school would have necessarily been trained because somebody may have graduated for some period of time, may not have worked with this, may not have been comfortable with that procedure. Not everybody knows every individual thing. They did not necessarily establish that they would know every individual angle either.

The fact that somebody could not perform it at that particular point does not mean that that person did not actually go through a college where it was offered because you do not know that, and I do not know that. He may just not have felt that he was qualified to perform the abortion or wanted to perform the abortion because the doctor has a choice whether to perform the abortion.

Dr. LING. That is exactly correct, and again, I want to reiterate that no one at ACOG, at the College, is trying to represent the need for abortion to be done by every physician. All we are trying to do is maximize the opportunities for patients to access knowledgeable physicians, whether or not they perform the abortion, so that if information is needed, if procedures are required, that they have a greater opportunity to receive that treatment or information. Either may be the case.

Mr. SOUDER. I will get to you in just a second, Dr. Smith. I had one other point I wanted to make, and that is that this is a tough debate. Those of us who are very much against Federal regulation of health care, if this did not come into the political arena the way it did, would be very uncomfortable with this type of debate even though I am very pro-life.

But Dr. Ling raised an even more controversial question that puts this over the edge, really, and that is that you said it was not just a matter of training. We have some of the mid-trimester questions, some of the details that we were going through there, but you said a lot of this is just making people so they can give better counseling and can give better advice to young girls considering this decision, which is clearly political since counseling is banned by Federal law because we do not allow Federal funds to be used for abortion counseling and have no intention.

That was when you were addressing the question of the procedures. You said it is more than just procedures, that you also need to be able to counsel, help a young person walk through the decision and do that. That is, if you have Federal funds involved in it, Federal abortion counseling.

Dr. LING. Mr. Souder, if I may clarify what I think is a misunderstanding on your part, if a patient asks a doctor, "What happens if I have an abortion? What are the potential consequences? How might I feel?" I think any physician would want to be able to provide that information to that patient. I think to take no position and give the patient no information is doing the patient and society a disservice.

All I was suggesting was that patients would receive better care if the physician that they are with can answer their questions. I believe that is better served by allowing those residents to have access to training during their training program.

Mr. SOUDER. I definitely understand your point as far as the technical, medical and safety, but when you get into abortion coun-

seling, you have entered a no-man's land, a very difficult subject, where it is a very fine line as you are counseling somebody between the health risks and the really moral, personal, family decision, and it takes very little time. It does not really require a special course to tell somebody the health risks.

Dr. LING. No, sir, and I agree with you 100 percent. I have found myself in that very position, trying to help a young woman, in some cases a very young woman, and her parents make a very difficult decision, and I believe that you are exactly correct.

However, as an obligation to a patient, those of us who provide medical care should be able to deal with those procedures and those techniques that are legal, and that certainly in this particular case I am not trying to imply that the physician should be directing a patient to obtain abortions. All I am trying to do is maximize the patient's access to the information that will allow them to get better health care.

Mr. SOUDER. I know Dr. Smith wants to make a closing comment in relation to that. I hope that you will take into extremely strong consideration so we may not have to do regulation that you have tilted the balance when you say you must publicize one side. In abortion counseling, at a very minimum, even on the medical facts, you should include the dangers of having an abortion and all the sides with that in that mix.

And, Dr. Smith, I said I would give you a chance. I am sorry I did not get to you quicker.

Dr. SMITH. Okay. Thank you.

I would like to say that I have worked 15 years in the inner city, and I have dealt with patients, every single patient that he has listed here. I have never done an induced abortion, and I have taken care of people in worse situations than this.

You do not need to do induced abortion, and particularly some of these dismemberment techniques. I have used things like prostaglandins and other things when you have to take care of the mother and her life is at risk. You do not need to learn the destructive techniques that have been discussed here. It is totally unnecessary in order to take care of critically ill patients.

And the second thing, I do a lot of abortion counseling because, number one, I take care of post-abortion syndrome victims who come to my office, who cannot get the counseling from the abortionists who do the procedure after the procedure, and because I am a primary care physician, many women all of whom know that I am pro-life will often ask me questions like, "Is it going to hurt? How much does it cost? I don't know what to do about this."

I think whether you are pro-life or pro-choice, if you are a physician and you are a primary care provider, you have to deal with this issue, particularly if you are an OB–GYN and you do not need pro abortion propaganda people to come and tell you how to do it. You do it because you care for the patient. You know the patient, and you empathize with the patient.

Mr. SOUDER. I thank the Chairman for his patience, and what we are talking about here is not the gag rule or prohibiting doctors from doing, but rather much like what we are having a vote on DOD on abortion counseling and funding with Federal funds, and

that is partly why we are involved in this debate, not on your individual practice, but because Federal funds are involved.

Thank you, Mr. Chairman.

Chairman HOEKSTRA. Thank you.

Just a couple of quick questions. Dr. Smith and Dr. Hannigan, perhaps a simple yes or no. Does this new language help your public institutions?

Dr. SMITH. No.

Dr. HANNIGAN. No.

Chairman HOEKSTRA. It does not solve your problems?

Dr. SMITH. No.

Dr. HANNIGAN. No.

Chairman HOEKSTRA. What would solve the problem, going back to the original language?

Dr. HANNIGAN. Going back to the original language. This, as we talked about earlier, may help the Catholic hospitals, but I work for the University of Texas, and I cannot make a statement on behalf of the State of Texas about what my moral feelings are about abortion. I would like to have some control over my residency program and what I teach and what I am required to teach.

Dr. SMITH. Also, it is a mistake to paint this as a Catholic versus non-Catholic position. There are institutions that are not Catholic that have problems with this, and there are institutions like my own where there is pro-life/pro-choice faculty that are going to have problems with this. So it is not just a Catholic versus non-Catholic.

Chairman HOEKSTRA. I would assume that there are public institutions around the country, hospitals, that do not do induced abortion procedures, correct?

Dr. HANNIGAN. Right.

Chairman HOEKSTRA. The question for Dr. D'Alessandri, the language that we have received today, is this the final language that you plan to implement on January 1?

Dr. D'ALESSANDRI. This is part of the final language that will be implemented.

Chairman HOEKSTRA. So this is the language that will be dealing with training on induced abortions that you plan on putting in place on January 1?

Dr. D'ALESSANDRI. That is correct, sir.

I just want to point out that any institution that has a moral, not necessarily a religious, but a moral objection to this does not have to provide the procedure. Any program, that word was also involved there, would not.

Chairman HOEKSTRA. So this is what we will be working with over the coming months, and we will be in dialogue with over the next six months?

Dr. D'ALESSANDRI. Yes, sir.

Chairman HOEKSTRA. All right. There is no opportunity to change it? This is it?

Dr. D'ALESSANDRI. Well, this is what has been approved by the council and we expect to be ratified by the RRC within the next couple of months, yes, sir.

Chairman HOEKSTRA. All right, and you recognize the implications that that may have?

Dr. D'ALESSANDRI. Well, I understand, sir, that as we have said this is a legal procedure.

Chairman HOEKSTRA. I am not arguing that. You understand the implications of where this puts this Congress on dealing with this issue and dealing with the ACGME?

Dr. D'ALESSANDRI. I do not understand that, sir.

Chairman HOEKSTRA. No, I am not asking you whether you understand our position or not. You understand that you taking that position means that this Congress or there will be Members of this Congress that are going to work for action on this issue. Do you understand that?

Dr. D'ALESSANDRI. I understand that.

Chairman HOEKSTRA. That is all I am asking. You understand that that is a position that some of us believe we are now put in, and that you have now involved us in the process.

Dr. D'ALESSANDRI. I do not believe we have involved you, sir. I believe you have involved yourselves.

Chairman HOEKSTRA. I believe you have. Congress is going to be involved in this issue. I just want you to understand. We can argue about who started this chain. It is your language that has gotten a lot of people very excited about an issue that up until this point in time. We seem to be moving along, and we seem to dealing fairly well at it.

I just wanted to make a couple of comments.

Mr. MCKEON. Mr. Chairman.

Chairman HOEKSTRA. Do you want some time for questions? I will yield to Mr. McKeon.

Mr. MCKEON. Thank you.

I apologize for not being able to hear much of the testimony, but this does remind me a little bit of the issue we had last year with the EEOC when they came out with some proposed language. However, they were willing to discuss it with us and some changes were arrived at. It sounds like we do not have that opportunity here, that they have not given us an opportunity to make any changes on this or any discussion, and I guess that is what you are alluding to, further action that would have to be taken.

Dr. D'ALESSANDRI. No, sir.

Mr. MCKEON. It seems like it is fair——

Dr. D'ALESSANDRI. I did not understand the question in that way, sir. I did not understand the question that way at all.

Mr. MCKEON. That is the way I understood it. I just asked a very clear question. Is this the language or is there an opportunity to influence it?

Dr. D'ALESSANDRI. I think there is always an opportunity to influence things. We would be happy to continue discussion on this matter.

Chairman HOEKSTRA. Will the gentleman yield?

Mr. MCKEON. Yes.

Chairman HOEKSTRA. That is the process?

Dr. D'ALESSANDRI. Well, we would be happy to engage your staff and set up a meeting. We would be happy to meet with you and have representatives from the ACGME and the RRC meet with you. We would be happy to do that, sir.

Chairman HOEKSTRA. Okay. Thank you.

I will yield back.

Mr. MCKEON. I am a great mediator, you know, being a real moderate on all of these issues.

[Laughter.]

Mr. MCKEON. Sir, I thank you.

May I yield some time to Dr. Weldon?

Dr. WELDON. I thank the gentleman for yielding, and I appreciate the opportunity to meet with members of the ACGME on this issue.

I guess I just have one remaining question, and that has to do with a particular instance that was brought to our attention involving the St. Agnes Hospital in Baltimore. I do not know if this was already brought up. I know I have had to go in and out.

They lost accreditation because of a lack of family planning program.

Dr. D'ALESSANDRI. That is not correct, sir.

Mr. WELDON. Was there more to that particular instance?

Dr. D'ALESSANDRI. Considerably more. Since that is a matter of public record, we generally do not discuss these issues in any detail in a public way, but that was litigated, and there were many issues involved in that case. This was only one of the issues that was part of it.

Mr. WELDON. Okay. That was the only question I had.

Chairman HOEKSTRA. Okay. Thank you.

Mr. WELDON. I thank the gentleman for yielding.

Mr. MCKEON. I yield back the balance of my time.

Chairman HOEKSTRA. Mr. Sawyer.

Mr. SAWYER. Well, Mr. Chairman, I just want to say that you have been certainly good to your word in terms of your fairness and openness. I will not repeat you. You at one point said you would have a liberal approach to this, and I do not ever want to have that be confused.

[Laughter.]

Mr. SAWYER. And you would not either, I am sure.

This is obviously a deeply emotional issue. It is one in which people have deep moral investment, and I just want you to know, Dr. Levatino, I read one of the articles that you had written that went into greater detail about your journey from where you had been to where you are, and I cannot know how you felt, but I have some deep sympathy with how you feel, and I appreciate your being here.

Mr. Chairman, I appreciate the quality and tone of this hearing. There have been a lot of hearings broadly on this topic across this Congress over recent years, and I would like it to be that this one has been constructive.

I do not think we have resolved anything here today, but I think we have set a constructive framework for further discussion of a difficult issue.

I particularly want to close from my point of view and get some reassurance at least from the representatives from ACGME about the intent of the language that talks about legal restrictions. I think it was Dr. Levatino who talked about the consequences of a variety of different State jurisdictions and their effects on the results of this kind of program requirement.

Is it your intention that those State statutory limitations be respected with regard to the carrying out of this requirement?

Dr. D'ALESSANDRI. Absolutely, sir.

Mr. SAWYER. Thank you very much. I appreciate it, Mr. Chairman.

Chairman HOEKSTRA. Thank you.

Any other Members who have any other questions?

[No response.]

Chairman HOEKSTRA. Just let me wrap up and make some closing comments and hopefully continue to be constructive, although somewhat frustrated by what I have heard today.

I came to this hearing and I conclude this hearing with a recognition that I believe that there is many individuals who would like to go into the medical profession who would not want to go through the parts of the training that you are now in a position of starting to require.

There are a number of institutions that would not want to offer that type of training and believe that by not offering that type of training, they can still provide excellent health care to the general public.

I was hoping today that as we went through this process that somewhere along the line there would be a clarity of why this policy was put in place, something other than it being driven by a political agenda. I do not believe I have seen that. I have tried to go through the arguments. I have not seen a compelling medical need demonstrated. I have not seen an identification that the procedures that are being done here and the types of applications that you would want to have them used for, that they are significantly different than the procedures that individuals are already trained in.

I have not seen strong professional support from the medical profession for this change, and it has been demonstrated here. It has also been demonstrated in contact with my office.

I sense no strong public demand or support for this type of change, and actually could argue that there would be strong public disagreement with the medical profession moving in this area.

Earlier the statement was made that the ACGME did not understand the position of the Catholic Health Association. I would lead you to consider that perhaps you do not understand the position of the American people and the public on this position. It is very clear that you do not understand the position of many Members of Congress on this issue.

I appreciate your offer to meet with us and to consider working out something that might be appropriate so that we do not have to go through a legislative procedure. I am somewhat offended; maybe I should not be, but I do not believe that this is a woman's health issue. I believe that it is a much deeper issue than just a woman's health issue.

You are trying to require training in things many doctors just do not want to do. You are trying to enforce a procedure that has been very, very divisive in this country, and you are moving it away from a position of choice to a requirement.

There was talk about now we have to do this for health care. The doctors are continually making choices about specialties and training and where they want an emphasis and where they will not.

They cannot be trained in everything. You have obviously made a decision that this is a priority that every doctor or every person in this profession, that this is one of the highest priorities. I do not necessarily see the compelling evidence coming out today for that.

I thank the panel for their testimony. I think we have learned some things. We have gotten a deeper understanding, but perhaps most importantly we have gotten a commitment that we will explore a way to address this issue. We will be in contact with you to try to set that up, to try to work through and resolve this issue.

If not successful or on a parallel track, we will continue the development of the legislation and building a consensus in Congress that something needs to be done on this issue.

So that is, I think, where we leave this hearing today, with an appreciation for your testimony, a commitment to work with you to see if we can reach an appropriate compromise, but also recognizing that the fact that that may not be possible, and we will be working on parallel tracks to make sure we keep this area and this direction within a framework and within limits that we feel comfortable with.

So thank you very much.

The subcommittee is adjourned.

[Whereupon, at 3:28 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows.]

OPENING STATEMENT
Congressman Pete Hoekstra, Chairman
Subcommittee on Oversight and Investigations
Committee on Economic and Educational Opportunities
Wednesday, June 14, 1995

ACCREDITATION STANDARDS FOR OB./GYN.
The New Abortion Mandate

Let me say from the outset that I would have preferred not to hold this hearing today. As a Congress, we rely heavily on the Accreditation Council for Graduate Medical Education (ACGME) for making sure that doctors educated in the United States are qualified. Unfortunately, in February of this year, the ACGME chose to expand the agenda of medical school accreditation far beyond simply establishing minimum standards for the profession and have launched into the area of taking sides in an extremely divisive moral and social issue. It seems clear to me that I, as the chairman of this oversight committee, and the Congress as a whole, have no choice but to address this issue.

Abortion has been called a "third rail" of American politics – an issue so hot that no one wants to touch it. The issue involves basic American values – personal liberty and the protection of innocent life - which seem to be in direct conflict. The dilemma often seems intractable, and emotions run high on both sides. This is why the word "pro-choice" is so appealing to many Americans. It suggests that everyone will agree to disagree, that each person is allowed to live in accord with his or her values.

Whatever the validity of this approach where human life may be at stake, some new developments cannot be called "pro-choice." They involve forcing medical training programs in obstetrics and gynecology to perform and teach abortion techniques against their will. Such developments seem both "anti-life" and "anti-choice."

It is of special concern to this committee that such coercion would be enforced by threatening to withhold accreditation from programs of graduate medical education. And the matter is of special concern to Congress, because such accreditation may determine whether programs and students receive educational loan benefits and other federal assistance.

This problem arose on February 14 of this year, when the ACGME issued new requirements for residency programs in obstetrics and gynecology. All ob./gyn. residency programs will be required to train residents in the various methods of induced abortion.

While individual students with "moral or religious objections" will be able to opt out, an advocate of the policy has already written that those who object "should be required to explain why in a way that satisfies stringent and explicit criteria" (Dr. Barbara Gottlieb, "Abortion -- 1995," in New England Journal of Medicine, 2/23/95, p. 532). Moreover, no program can completely opt out. Even Catholic programs and others with strong moral objections must set up mechanisms to make sure the training is provided at another location. No conscience protection is provided for faculty members and their staff.

The new requirement, scheduled to take effect on January 1, runs directly counter to numerous state and federal enactments on this issue. Federal conscience clauses seek to ensure that physicians, students and residents in medical schools and hospitals will not be discriminated against for refusing to participate in abortion (42 USC § 300a-7). In 1988, Congress amended the Education Amendments of 1972 to ensure that federal "sex discrimination" provisions do not require any educational program or institution to provide abortion benefits to staff and students. The Religious Freedom Restoration Act of 1993 allows any institution to file federal suit if a law or regulation would require it to act contrary to its religiously based moral code.

The ACGME requirement threatens to place federal law in conflict with itself. Medicare reimburses for medical procedures performed by medical residents only if their residency program is accredited by the ACGME (42 USC § 139x (b) (6), 42 CFR § 405.522). The Health Education Assistance Loan (HEAL) program allows graduates of medical schools to defer repayment of their student loans during residency, but only if the residency program is accredited by ACGME (42 CFR § 60.11). How can Congress so firmly proclaim protection for students and facilities that refuse participation in abortion, and then punish them by denying them the benefits of these federal programs ?

The conflict in state law is no less troubling. At least 41 states have laws protecting the rights of individuals and facilities that refuse to participate in abortion. My own state of Michigan declared that a "hospital, clinic, institution, teaching institution, or other health facility" may not be required to perform or participate in abortions, and that such facilities have immunity against any "civil or criminal liability or penalty" (Mich. State. Ann. § 333.20181). Almost every member of this subcommittee comes from a state with a similar law. And yet many of these same states deny a license to practice medicine to a resident if his or her residency program is not accredited by the ACGME. If that accreditation rests in whole or in part on willingness to provide abortion training, the state has been placed in an untenable position. It seems to be violating its own anti-discrimination law.

Within the medical profession, the new requirement runs counter to current practice and many doctors' convictions. Some witnesses who are present today can speak more credibly than I about the depth of physicians' disagreements on this issue. I would only note that the expressed reason for the new ACGME requirement is the widespread unwillingness of ob./gyn. programs to make abortion an integral part of their training. Program and faculty have been voting with their feet. By one recent study, only 12 percent of ob./gyn. residency programs make abortion a routine part of their training; most programs make it available as an optional elective, but then few residents volunteer for the training. It seems that the new requirement must be imposed from outside precisely because physicians and residents in the field do not see it as an integral part of responsible medicine.

The broader issue before us is whether accreditation of educational programs is supposed to ensure basic competency in a field, or to enforce conformity with the ideological view of an organization that has acquired a monopoly on the accreditation process. When that organization enjoys delegated governmental power to determine eligibility for federal benefits, it would be irresponsible for Congress to ignore such abuse. Simply to preserve the legal status quo, to preserve everyone's current right to choose whether or not to participate in abortion, new federal action may be necessary. In my view at least, Congress cannot be idle when eligibility for its own programs of federal assistance is condition on involvement in abortion. For this reason, I am developing legislation to be introduced in the coming days which will protect institutions and individuals from being discriminated against based on their refusal to perform induced abortions.

But today's hearing does not concern particular legislation. It brings together a representative of the ACGME, and several directors and faculty in ob.gyn. programs, to deepen our understanding of this problem. What has ACGME done and why? Where is this policy leading, and what does it mean for the integrity of standards for the educational accreditation?

I welcome all the witnesses who have agreed to be with us today, and I invite my colleagues to present any opening statements that they may have.

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